State of Michigan

Department of Community Health

Michigan Medicaid HEDIS® 2003 Results
STATEWIDE AGGREGATE REPORT

DECEMBER 2003

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CONTENTS

1. Executive Summary

2. How to Get the Most From This Report

3. Pediatric Care

4. Women's Care

5. Living with Illness

6. Access to Care

7. Systemic Issues

Appendices

TABLES AND FIGURES

These figures and tables are all for Michigan Medicaid HEDIS 2003, except where otherwise specified.

1. Executive Summary

2. How to Get the Most From This Report

3. Pediatric Care

4. Women's Care

5. Living with Illness

6. Access to Care

7. Systemic Issues

(No figures or tables in this section.)

Appendices

ACKNOWLEDGMENTS AND COPYRIGHTS

1. Executive Summary

Introduction

During the year 2002, Michigan Department of Community Health (MDCH) contracted with 18 health plans to provide managed care services to more than 831,000 Michigan Medicaid enrollees[1-1]. To evaluate performance levels, MDCH implemented a system to provide objective, comparative review of health plan quality-of-care outcomes and performance measures. One component of the evaluation system is based on the Health Plan Employer Data and Information Set (HEDIS®). Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. MDCH selected 15 HEDIS measures from the standard Medicaid HEDIS reporting set as the Key Measures for evaluating performance of the Michigan Medicaid health plans. These 15 measures are comprised of 33 distinct rates.

MDCH expects its contracted health plans to support health care claims systems, membership and provider files, and hardware/software management tools which facilitate accurate and reliable reporting of HEDIS measures. MDCH has contracted with Health Services Advisory Group, Inc. (HSAG) to objectively analyze Michigan Medicaid health plan HEDIS results and to evaluate each health plan's current performance levels relative to national Medicaid percentiles. MDCH uses HEDIS rates for the annual Medicaid consumer guide, as well as for annual performance assessment.

Performance levels for Michigan Medicaid health plans have been established for all of the Key Measures. The performance levels have been set at specific, attainable rates and are based on national percentiles. This standardization allows for comparison to the performance levels. Health plans meeting the High Performance Level (HPL) exhibit rates among the top in the nation. The Low Performance Level (LPL) has been set to identify health plans in the greatest need of improvement. Details are shown in Section 2 ("How to Get the Most From This Report").

HSAG has examined the Key Measures along four different dimensions of care: Pediatric Care, Women's Care, Living with Illness, and Access to Care. These dimensions reflect important groupings and expand on the dimensions model used by the Foundation for Accountability (FACCT). This approach to the analysis is designed to encourage consideration of the Key Measures as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

Michigan Medicaid HEDIS results are analyzed in this report in several ways. For each of the four dimensions of care:

- A weighted average comparison presents the Michigan Medicaid 2003 results relative to the 2002 Michigan Medicaid weighted average and the national HEDIS 2002 Medicaid 50th percentiles.

[1-1] State of Michigan. Michigan Department of Community Health. Enrollment Services. Section Report BN-271. Run Date May 1, 2003.

- A performance profile analysis discusses the overall Michigan Medicaid 2003 results and presents a summary of health plan performance relative to the Michigan Medicaid performance levels.
- A health plan ranking analysis provides a more detailed comparison, showing results relative to the Michigan Medicaid performance levels.
- A data collection analysis evaluates the potential impact of data collection methodology on reported rates.

In addition, Section 7 ("Systemic Issues") of the report provides a summary of the global issues that the Michigan Medicaid health plans face in the collection and calculation of rates for HEDIS measures.

Key Findings and Recommendations

The addition of Access to Care as a new dimension of analysis is an important step by MDCH, since health plan performance in the Access to Care measures will ultimately impact results in all of the other dimensions, either positively or negatively. In 2003, highlighting Access to Care results in this way showed that performance was poor in this dimension, with all six Michigan Medicaid aggregate rates falling below the national HEDIS 2002 Medicaid 50th percentile. In addition, aggregate rates fell compared to 2002 for *Adults' Access to Preventive/Ambulatory Health Services* in all age groups. Improving performance in this dimension should be an overall priority for Michigan Medicaid health plans. An analysis of barriers to care should be completed by all health plans and should encompass all potential barriers, including those that involve the patient, the provider, and the system of care.[1-2]

Patient barriers include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive care. Health provider barriers include limited time, lack of training in prevention, lack of perceived effectiveness of selected preventive services, and practice environments that fail to facilitate prevention. Computerized or manual tracking systems, patient and clinician reminders, clinical guidelines, and patient information materials can help providers improve delivery of necessary preventive care.[1-3] System barriers can include lack of resources or attention devoted to prevention, lack of coverage or inadequate reimbursement for services, and lack of systems to track the quality of care. Systems interventions that can increase delivery of health care include offering clinical preventive services among standard covered benefits, providing feedback on performance to providers and practices, offering incentives for improved performance, and developing and implementing systems to identify and provide outreach to patients in need of services.[1-4] HSAG recommends health plans incorporate patient, provider, and system interventions as mentioned above for all Access to Care measures.

MDCH should expand upon its current research collaborative with the Institute for Health Care Studies (IHCS) at Michigan State University to include access to care for adults. Findings of the IHCS research indicate that the access issues are not only the traditional barriers to care noted above, but include lack of member knowledge regarding the value of well-care visits. Methods to

[1-2] Agency for Healthcare Research and Quality. *Healthy People 2010: Access to Quality Health Services.* Available at: http://www.healthypeople.gov/document/html/volume1/01access.htm. Accessed on September 8, 2003.
[1-3] Ibid.
[1-4] Ibid.

improve access should be explored using multiple approaches, covering possible limitations to access by providers, as well as addressing this apparent lack of understanding on the part of members as to the importance of preventive visits. This may entail developing and testing more effective messages to encourage participation by members, and improved methods to reach Medicaid recipients in need of care.

MDCH's efforts to increase immunization rates through the use of the Michigan Childhood Immunization Registry (MCIR) has had a positive impact on reported rates for both *Childhood Immunization Status* and *Adolescent Immunization Status*. These rates now appear to accurately reflect the care children are receiving; and, therefore, future interventions to improve results may need to also focus on access to care issues. Well-care visits for children is also an area of lower performance in the Michigan Medicaid managed care program, and, over time, is likely to benefit from interventions addressing the findings from the IHCS collaborative.

Maternal care as measured by these quality indicators also shows some potential access issues. Prenatal and postpartum care rates are low, and aggregate rates have also declined in the last year. MDCH and the health plans should consider additional research to determine if there are specific barriers to maternal care or if, as in well-child visits, non-compliance is the result of a lack of member knowledge regarding the value of these visits.

Care for Michigan Medicaid members with diabetes and asthma is average compared to other managed Medicaid programs nationally. However, the new Key Measure *Controlling High Blood Pressure* is low compared with national Medicaid results. MDCH should encourage collaboration among health plans to look at this new measure and suggest methods for improvement.

Performance overall by certain Michigan Medicaid health plans warrants recognition. Compared to national HEDIS percentiles, these health plans have shown excellent performance in one or more of the dimensions of care, or have demonstrated significant improvement in each of the last two years in several measures. M-CAID demonstrated outstanding performance in the areas of Pediatric Care and Living with Illness. Priority Health Government Programs also demonstrated exceptional performance in the Living with Illness dimension. Two health plans, Cape Health Plan and Molina Healthcare of Michigan, achieved statistically significant improvements in several measures in the Living with Illness dimension. MDCH should continue to promote health plan sharing of best practices through the Clinical Advisory Committee, the Mental Health Advisory Committee, and the Michigan Association of Health Plan Quality Improvement Directors' Committee.

Weighted Average Comparisons for the Four Dimensions of Care

Figure 1-1 through Figure 1-4, on the following pages, present Michigan Medicaid HEDIS 2003 results for each dimension of care, comparing the current weighted average for each measure relative to the 2002 Michigan Medicaid weighted average and the national HEDIS 2002 Medicaid 50th percentile.

In each figure, the following information will help the reader interpret these data.

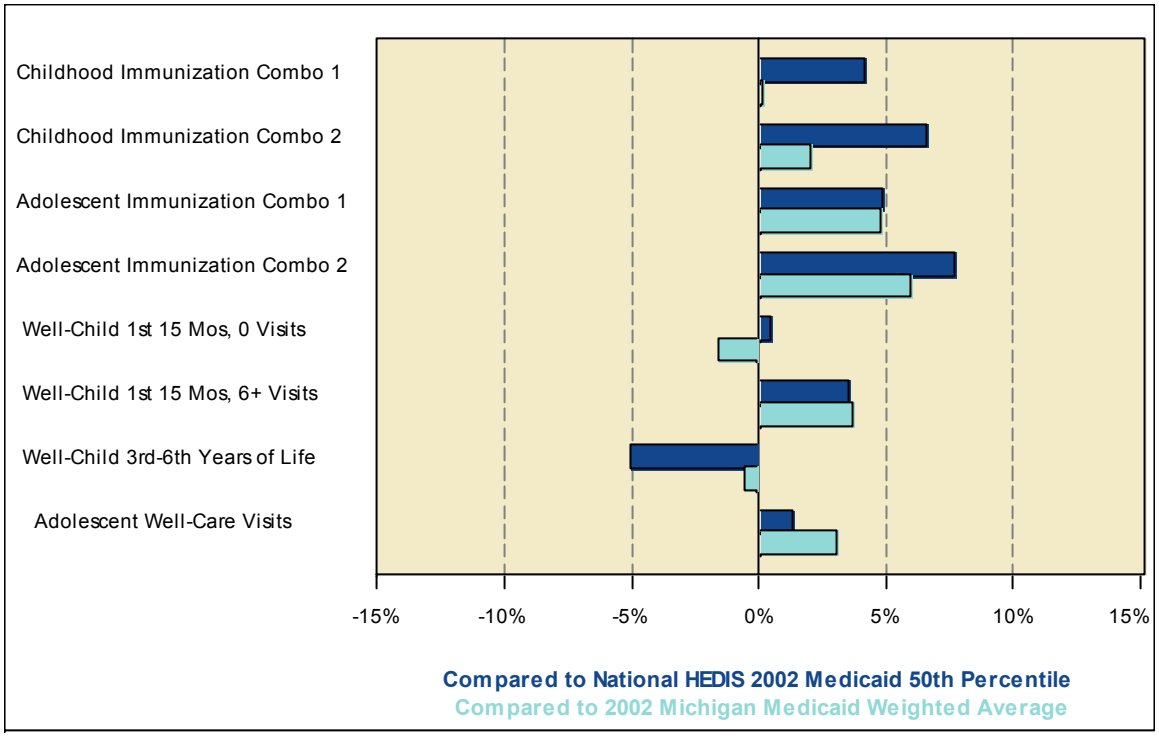
- The light-colored bars show the difference in percentage points between this year's Michigan results and last year's Michigan results, comparing the 2003 and 2002 Michigan Medicaid weighted averages.
- The dark-colored bars show the difference in percentage points between this year's Michigan results and the national results, comparing the 2003 Michigan Medicaid weighted average with the national HEDIS 2002 Medicaid 50th percentile.
- For all measures (except two), a bar to the **right** indicates an **improvement** in performance and a bar to the **left** indicates a **decline** in performance.

  The two exceptions are:

  Well-Child Visits in the First 15 Months of Life–Zero Visits, and
  Comprehensive Diabetes Care – Poor HbA1c Control

  For these exceptions, **lower** rates (a bar to the left) indicates **better** performance.

Figure 1-1—Michigan Medicaid HEDIS 2003 Weighted Average Comparison: Pediatric Care



Note: For *Well-Child Visits in the First 15 Months of Life–Zero Visits,* a bar to the *left* (lower rates) indicates *better* performance.

Figure 1-2—Michigan Medicaid HEDIS 2003 Weighted Average Comparison: Women's Care

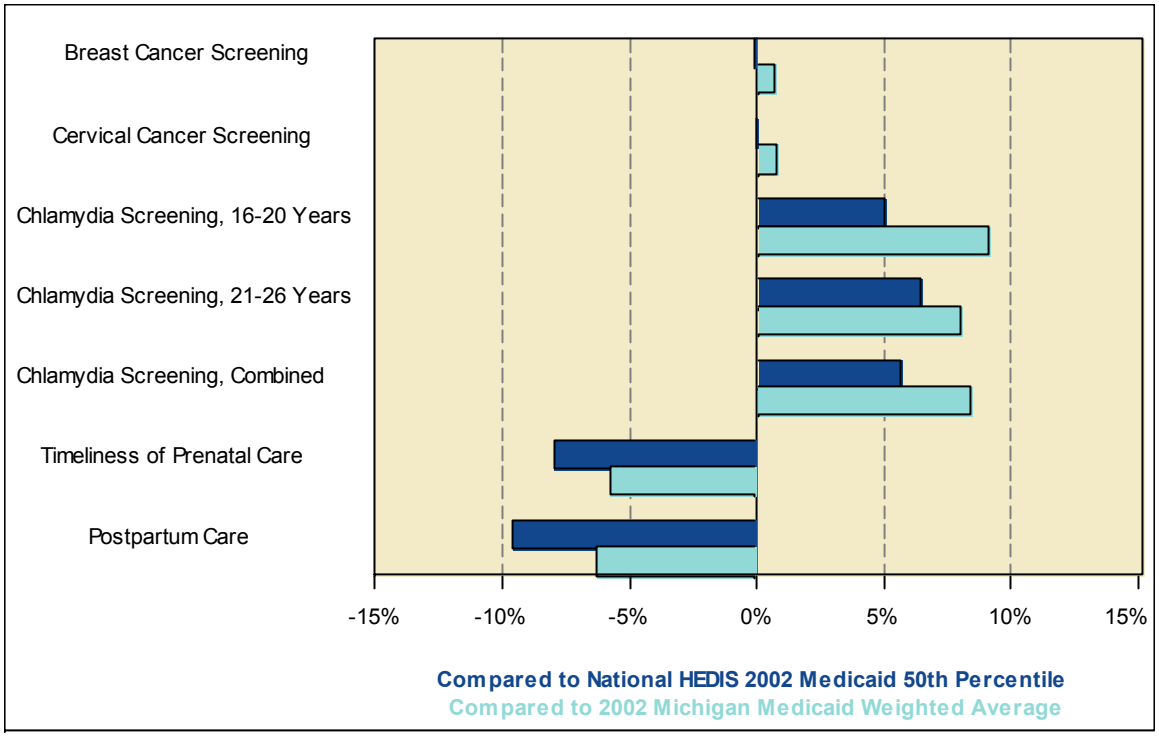
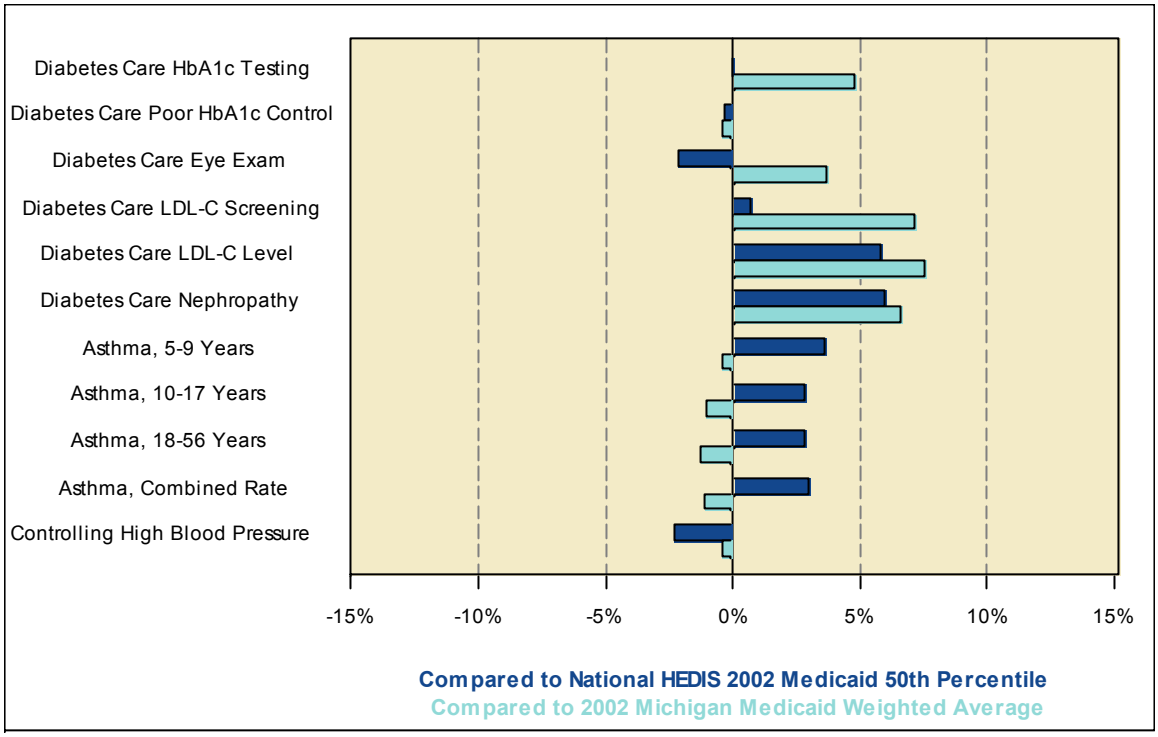
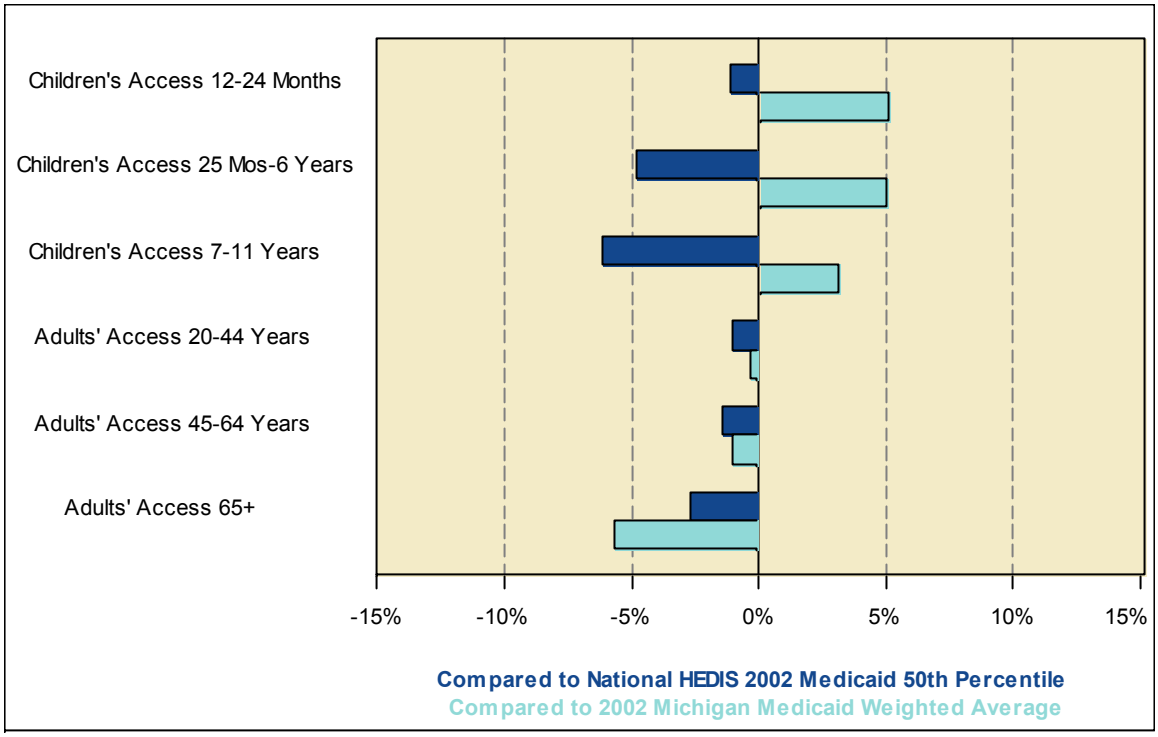


Figure 1-3—Michigan Medicaid HEDIS 2003 Weighted Average Comparison: Living with Illness



Note: For *Comprehensive Diabetes Care – Poor HbA1c Control,* a bar to the *left* (lower rates) indicates *better* performance.

Figure 1-4—Michigan Medicaid HEDIS 2003 Weighted Average Comparison: Access to Care



Pediatric Care Performance Profile Analysis

Summary

Pediatric Care results are mixed. Positive results in childhood immunizations have been sustained and are beginning to carry over to also show improvement in adolescent immunizations, with fewer health plans reporting rates below the LPL. The Michigan aggregate *Adolescent Immunization Status – Combination #2* rate has shown a statistically significant improvement over the 2002 aggregate rate. However, well-care visits lag behind the success seen in immunizations, with two of the aggregate well-care visit rates worse than the national HEDIS 2002 Medicaid 50th percentile: *Well-Child Visits in the First 15 Months of Life – Zero Visits* and *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*.

Within the Pediatric Care dimension, the top performing Michigan Medicaid health plan was M-CAID, which achieved the HPL in six out of eight Pediatric Care measures. Although the M-CAID rates for *Adolescent Immunization Status – Combination #1* and *Combination #2* did not meet the HPL, both were above the 75th percentile and the highest reported rates among all the Michigan Medicaid health plans.

Immunization Status

Childhood Immunization Status rates continue to be a strength for Michigan Medicaid health plans. The aggregate rates for *Combination #1* and *Combination #2* are above the national HEDIS 2002 Medicaid 50th percentile, with no statistically significant difference from 2002 rates. Five health plans reported *Combination #1* rates above the HPL, and four reported *Combination #2* rates above the HPL. Low, but reportable, rates from OmniCare Health Plan indicate an improvement over its *Not Report* rates from last year. This, however, created an increase in the range of rates reported with a higher maximum rate but much lower minimum than last year.

Both the *Adolescent Immunization Status Combination #1* and *Combination #2* aggregate rates are above the national HEDIS 2002 Medicaid 50th percentile. Adolescent immunization rates are also improving: the Michigan Medicaid aggregate rate for *Combination #2* shows a significant improvement over 2002 results, from 14.8 percent to 20.7 percent. While no health plan achieved the HPL, the only rate below the LPL was *Combination #1* for OmniCare Health Plan.

Well-Child and Well-Care Visits

Rates for *Well-Child Visits in the First 15 Months of Life* continue to show opportunity for improvement. The Michigan Medicaid aggregate performance for *Zero Visits* is higher than the national HEDIS 2002 Medicaid 50th percentile, indicating poorer performance. Although the rate for *Six or More Visits* indicates better performance than the national HEDIS 2002 Medicaid 50th percentile, neither aggregate rate has shown statistically significant change from 2002. There has been some improvement, with two health plans exceeding the HPL for the *Zero Visits* rate in 2003, compared to none in 2002. However, four health plans still had rates fall below the LPL for *Zero Visits*. In addition, three health plans had rates which fell below the LPL for *Six or More Visits*, and this was one more than in 2002. On a positive note, all 18 health plans were able to report these rates.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life is a measure that also presents opportunity for improvement. The 2003 Michigan Medicaid aggregate rate is well below the national HEDIS 2002 Medicaid 50th percentile, and has not shown a statistically significant change

from 2002. The health plan-specific results are also of concern, with only one health plan reporting a rate exceeding the HPL and four health plans with reported rates below the LPL.

The 2003 Michigan Medicaid aggregate rate for *Adolescent Well-Care Visits* has not changed significantly from last year, and is above the national HEDIS 2002 Medicaid 50th percentile. There has been improvement in health plan-specific results. The highest reported rate of 64.5 percent exceeds the HPL, and is 25.1 percentage points above last year's highest reported rate. Furthermore, no health plans reported a rate below the LPL, compared to three health plans last year.

Figure 1-5—Michigan Medicaid HEDIS 2003 Performance Summary: Pediatric Care

Health Plan Code	Childhood Immunization Combo 1	Childhood Immunization Combo 2	Adolescent Immunization Combo 1	Adolescent Immunization Combo 2	Well-Child 1st 15 Mos, 0 Visits	Well-Child 1st 15 Mos, 6+ Visits	Well-Child 3rd–6th Years of Life	Adolescent Well-Care Visits
BOT	★	★★	★★	★★	★	★★	★★	★★
CAP	★★	★★	★★	★★	★★	★★	★★	★★
CCM	★★	★★	★★	★★	★★	★	★	★★
CCP	★★★	★★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★	★★	★★
HPP	★★★	★★★	★★	★★	★★	★★	★★	★★
MCD	★★★	★★★	★★	★★	★★★	★★★	★★★	★★★
MCL	★★	★★	★★	★★	★★	★★	★★	★★
MID	★★	★★	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★	★★	★	★★
OCH	★	★	★	★★	★	★	★	★★
PMD	★★	★★	★★	★★	★★	★★	★★	★★
PRI	★★	★★	★★	★★	★★	★★	★★	★★
PSW	★★★	★★★	★★	★★	★★	★★	★★	★★
THC	★★	★★	★★	★★	★	★	★	★★
TWP	★★	★★	★★	★★	★★	★★	★★	★★
UPP	★★★	★★	★★	★★	★★★	★★	★★	★★
3-star count	5	4	0	0	2	1	1	1
2-star count	11	13	17	18	12	14	13	17
1-star count	2	1	1	0	4	3	4	0

This symbol		shows this performance level
3 stars	★★★	≥ HPL
2 stars	★★	> LPL and < HPL
1 star	★	≤ LPL, or for *Not Report (NR)*

Women's Care Performance Profile Analysis

Summary

Performance in Women's Care is mixed, with little change in cancer screening, statistically significant improvement in all rates for *Chlamydia Screening in Women,* and poor performance in prenatal and postpartum care. Maternal care is a major area of concern in the Michigan Medicaid 2003 results. Both the *Timeliness of Prenatal Care* and *Postpartum Care* aggregate rates are below the national HEDIS 2002 Medicaid 50th percentile, with the *Postpartum Care* rate less than one percentage point above the 25th percentile. In addition, the aggregate rates for both measures show a decrease when compared to 2002 rates.

None of the Michigan Medicaid health plans demonstrated exceptional performance in the area of Women's Care, except Botsford Health Plan, which achieved the HPL for all three *Chlamydia Screening in Women* Key Measures. Targeted interventions used by Botsford Health Plan to improve the *Chlamydia Screening in Women* rates may be beneficial to share with the other Michigan Medicaid health plans.

Cancer Screening

The Michigan Medicaid *Breast Cancer Screening* aggregate rate is slightly below the national HEDIS 2002 Medicaid 50th percentile, and shows no significant change from 2002. Health plan-specific results show some improvement with three health plans reporting rates above the HPL, compared to one last year, and two health plans reporting rates below the LPL in 2003, one fewer than last year.

The *Cervical Cancer Screening* aggregate rate is above the national HEDIS 2002 Medicaid 50th percentile, and is not statistically different from the 2002 aggregate rate. One health plan (Priority Health Government Programs) now has a reported rate above the HPL, and two health plans report rates below the LPL (compared to three in 2002). The range of health plan-specific rates has shown a slight reduction in size of approximately 5 percentage points.

Chlamydia Screening

Chlamydia Screening in Women rates are above the national HEDIS 2002 Medicaid 50th percentiles, and aggregate rates show statistically significant improvement in all age groups when compared to 2002. Two health plans reported two or more of their rates above the HPL, and only one health plan reported a rate for one age group which was below the LPL. These results compare favorably to 2002, when no health plan reported a rate above the HPL in any age group.

Maternal Care

The maternal care measures are the lowest in this dimension. Both the *Timeliness of Prenatal Care* and *Postpartum Care* aggregate rates are below the national HEDIS 2002 Medicaid 50th percentile. Both of these aggregate rates are also below the 2002 Michigan aggregate rates, although the differences are not statistically significant. In 2003, no health plan reported a rate above the HPL for either measure. In addition, four health plans reported rates below the LPL for *Timeliness of Prenatal Care* and seven health plans reported rates below the LPL for *Postpartum Care*. This performance contrasts with last year, when three health plans reported rates above the HPL for *Timeliness of Prenatal Care,* and two were above the HPL for *Postpartum Care*.

Figure 1-6—Michigan Medicaid HEDIS 2003 Performance Summary: Women's Care

Health Plan Name	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening, 16-20 Years	Chlamydia Screening, 21-26 Years	Chlamydia Screening, Combined	Timeliness of Prenatal Care	Postpartum Care
BOT	★★	★★	★★★	★★★	★★★	★	★
CAP	★★	★★	★★	★★	★★	★★	★
CCM	★★	★★	★★	★★	★★	★★	★★
CCP	★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★	★★
HPP	★★	★★	★★	★★	★★	★★	★★
MCD	★★	★★	★★	★★	★★	★★	★★
MCL	★★★	★★	★★	★★	★★	★★	★★
MID	★★	★	★★	★★	★★	★	★
MOL	★	★★	★★	★★	★★	★	★
OCH	★★	★	★★	★★	★★	★	★
PMD	★★	★★	★★	★★	★★	★★	★★
PRI	★★	★★★	★★	★★	★★	★★	★★
PSW	★★★	★★	★★	★★	★★	★★	★★
THC	★	★★	★★	★★	★★	★★	★
TWP	★★	★★	★★	★★★	★★★	★★	★
UPP	★★★	★★	★★	★★	★★	★★	★★
3-star count	3	1	1	2	2	0	0
2-star count	13	15	16	16	16	14	11
1-star count	2	2	1	0	0	4	7

This symbol		shows this performance level
3 stars	★★★	≥ HPL
2 stars	★★	> LPL and < HPL
1 star	★	≤ LPL, or for *Not Report (NR)*

Living with Illness Performance Profile Analysis

Summary

Overall, results for this dimension of care are positive, with *Comprehensive Diabetes Care* aggregate results generally above the national HEDIS 2002 Medicaid 50th percentile. The one exception is the rate for the retinal *Eye Exam,* which is below the national HEDIS 2002 Medicaid 50th percentile, although the aggregate rate is improving when compared to last year. Results for asthma care are also positive, with Michigan Medicaid aggregate rates for *Use of Appropriate Medications for People with Asthma* above the national HEDIS 2002 Medicaid 50th percentile for all age groups. For the *Combined Rate,* five health plans reported results above the HPL, and none were below the LPL.

The weakest area in the management of chronic conditions is for the new Key Measure, *Controlling High Blood Pressure*. For this measure, the Michigan Medicaid aggregate rate is below the national HEDIS 2002 Medicaid 50th percentile, and three health plans reported rates below the LPL.

The methodology for the measure, *Medical Assistance with Smoking Cessation - Advising Smokers to Quit,* changed in 2003; therefore, no comparative data are available. There was little variation in health plan performance for this measure, with rates ranging from 61.0 percent to 71.6 percent.

Within the Living with Illness dimension, two health plans demonstrated exceptional performance. Priority Health Government Programs and M-CAID both achieved the HPL in 9 out of 11 Key Measures. Both health plans have interventions and quality improvement activities in place that appear to be very successful. Priority Health Government Programs has also focused efforts on community awareness and community partnerships, an innovative approach to improving care provided to Medicaid members.

Two health plans demonstrated notable performance in the Living with Illness dimension. Cape Health Plan had statistically significant improvements for both of the past two years in 7 out of the 11 measures in this dimension. Molina Healthcare of Michigan also demonstrated statistically significant improvements for both of the past two years in three *Comprehensive Diabetes Care* Key Measures.

Comprehensive Diabetes Care

The Michigan aggregate rates for *Comprehensive Diabetes Care* are all better than the national HEDIS 2002 Medicaid 50th percentile, with the exception of the rate for the retinal *Eye Exam*, which fell below the national HEDIS 2002 Medicaid 50th percentile. The *LDL-C Screening* and *LDL-C Level* Michigan Medicaid aggregate rates have shown statistically significant improvement over the 2002 results. Generally, more health plans reported rates that met the HPL than reported rates below the LPL. Again, the exception to this was the retinal *Eye Exam* rate, in which no health plan rate met the HPL, and two health plans reported rates below the LPL.

Asthma Medication Management

The Michigan Medicaid aggregate rates for *Use of Appropriate Medications for People with Asthma* are above the national HEDIS 2002 Medicaid 50th percentile for all age groups. In 2003, the range of health plan results reported narrowed for all rates when compared with 2002. This was consistently due to higher minimum reported rates in 2003, but also lower maximum reported rates. While Michigan Medicaid aggregate rates appear to have declined slightly for all age groups, none had a statistically significant change when compared to 2002.

Controlling High Blood Pressure

The Michigan aggregate rate for *Controlling High Blood Pressure* is below the national HEDIS 2002 Medicaid 50th percentile and shows no significant change from 2002. Health plan-specific results are mixed, with three health plans reporting rates above the HPL, and three reporting rates below the LPL. The majority of the health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

Medical Assistance with Smoking Cessation

The Michigan Medicaid aggregate rate for this measure is 66.2 percent, and the health plan-specific rates range from a high of 71.6 percent to a low of 61.0 percent. The specifications for this measure were revised for HEDIS 2003; therefore, no comparison data or trending information is available.

Figure 1-7—Michigan Medicaid HEDIS 2003 Performance Summary: Living with Illness

Health Plan Name	Diabetes Care HbA1c Testing	Diabetes Care Poor HbA1c Control	Diabetes Care Eye Exam	Diabetes Care LDL-C Screening	Diabetes Care LDL-C Level	Diabetes Care Nephropathy	Asthma, 5–9 Years	Asthma, 10–17 Years	Asthma, 18–56 Years	Asthma, Combined	Controlling High Blood Pressure
BOT	★★	★★	★★	★★	★★	★★	NA	NA	★★	★★	★★
CAP	★★	★★	★★	★★	★★	★	★★	★★	★★	★★	★★
CCM	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★
CCP	★★★	★★	★★	★★	★★★	★★	★★	★★★	★★	★★★	★★
GLH	★★	★★	★★	★★	★★	★★	★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★
HPP	★★	★★	★★	★★	★★	★★	★★★	★★★	★★	★★★	★★
MCD	★★★	★★★	★★	★★★	★★★	★★★	★★	★★★	★★★	★★★	★★★
MCL	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★
MID	★	★	★	★★	★★	★★	★	★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★	★
OCH	★	★★	★★	★	★★	★★	★	★★	★★	★★	★
PMD	★★	★★	★★	★★★	★★★	★★★	★★★	★★	★★	★★	★★
PRI	★★★	★★★	★★	★★★	★★★	★★★	★★★	★★★	★★	★★★	★★★
PSW	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★	★★
THC	★	★	★	★★	★★	★★	★★	★★	★★	★★	★
TWP	★★	★★	★★	★★	★★	★★★	★★	★★	★★	★★	★★
UPP	★★★	★★★	★★	★★★	★★★	★★★	★★★	★★	★★	★★★	★★★
3-star count	4	3	0	4	5	5	4	4	1	5	3
2-star count	11	13	16	13	13	12	10	12	17	13	12
1-star count	3	2	2	1	0	1	3	1	0	0	3
NA count	0	0	0	0	0	0	1	1	0	0	0

This symbol		shows this performance level
3 stars	★★★	≥ HPL
2 stars	★★	> LPL and < HPL
1 star	★	≤ LPL, or for *Not Report (NR)*

"NA" means "Not Applicable."

Access to Care Performance Profile Analysis

Summary

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States. However, Michigan Medicaid performance is poor for all rates in this new dimension, which is overall the weakest of the four dimensions of care. Michigan Medicaid aggregate rates are consistently below the national rates, with all six falling below the national HEDIS 2002 Medicaid 50th percentile. Aggregate rates also fell compared to 2002 for *Adults' Access to Preventive/Ambulatory Health Services* in all age groups, although these changes were not statistically significant. More health plans reported rates below the LPL than reported rates above the HPL, except for the rate *for Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years*. Improving performance in this dimension should be an overall priority for Michigan Medicaid health plans.

None of the Michigan Medicaid health plans demonstrated exceptional performance consistently across all the Key Measures in the Access to Care dimension, although M-CAID achieved the HPL in *Children's Access to Primary Care Practitioners – Ages 7 to 11 Years, Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years and Ages 45 to 64 Years.* Health plan performance on these Key Measures is particularly susceptible to data completeness issues. Three health plans did not meet or exceed the LPL on all measures in this dimension. It is likely that once these health plans enhance their administrative data completeness, the rates in this dimension will improve.

Children's Access to Care

Michigan Medicaid aggregate rates for the *Children's Access to Primary Care Practitioners* measure fell below the national HEDIS 2002 Medicaid 50th percentile for all age groups, and the aggregate rate for *Ages 7 to 11 Years* was only 0.3 percentage points above the LPL. There was no statistically significant change in aggregate rates from 2002 to 2003. Only two health plans reported any one of the three *Children's Access to Primary Care Practitioners* rates above the HPL. Three health plans reported rates for all age groups below the LPL. Two more health plans had rates below the LPL for two out of the three age groups.

Adults' Access to Care

The Michigan Medicaid aggregate rates for *Adults' Access to Preventive/Ambulatory Health Services* - *Ages 20 to 44 Years* and *Ages 45 to 64 Years*, were both below the national HEDIS 2002 Medicaid 50th percentiles. The aggregate rate for *Ages 65+* rate is not presented, as only one of the 18 health plans was able to report this rate and all others were designated NA due to small denominators of less than 30. Two health plans reported rates above the HPL for *Ages 20 to 44 Years*, and four reported rates below the LPL. In the *Ages 45 to 64 Years* group, six health plans reported rates above the HPL, and five reported rates below the LPL. These results show wide variation in performance across the 18 Michigan Medicaid health plans. Since access to care is measured using only administrative data, which is largely complete, there is substantial room for improvement in this area.

Figure 1-8—Michigan Medicaid HEDIS 2003 Performance Summary: Access to Care

Health Plan Name	Children's Access 12 to 24 mos	Children's Access 25 mos to 6 yrs	Children's Access 7 to 11 yrs	Adults' Access 20 to 44 yrs	Adults' Access 45 to 64 yrs	Adults' Access 65+ yrs
BOT	★	★	★	★	★	NA
CAP	★★	★★	★★	★	★	NA
CCM	★★	★★	★★	★★	★★	NA
CCP	★★	★★	★★	★★	★★★	NA
GLH	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	NA
HPP	★★★	★★	★★	★★	★★★	NA
MCD	★★	★★	★★★	★★★	★★★	NA
MCL	★★	★★	★★	★★	★★	NA
MID	★	★★	★★	★★	★★	NA
MOL	★	★	★★	★★	★★	NA
OCH	★	★	★	★	★	NA
PMD	★★	★★	★★	★★	★★	NA
PRI	★★	★★	★★	★★	★★★	NA
PSW	★★	★★	★★	★★	★★★	NA
THC	★	★	★	★	★	NA
TWP	★★	★	★	★★	★	NA
UPP	★★	★★	★★	★★★	★★★	NA
3-star count	1	0	1	2	6	0
2-star count	12	13	13	12	7	1
1-star count	5	5	4	4	5	0
NA count	0	0	0	0	0	17

This symbol		shows this performance level
3 stars	★★★	≥ HPL
2 stars	★★	> LPL and < HPL
1 star	★	≤ LPL, or for *Not Report (NR)*

"NA" means "Not Applicable."

2. How to Get the Most From This Report

Michigan Medicaid HEDIS 2003 Key Measures

HEDIS includes a standard set of measures that can be reported by Medicaid health plans nationwide. MDCH selected 15 HEDIS measures from the standard Medicaid set and divided them into 33 distinct rates, shown in Table 2-1 below. These 33 rates represent the 2003 MDCH Key Measures. For HEDIS 2003, 18 Michigan Medicaid health plans were required to report these Key Measures.

Table 2-1—Michigan Medicaid HEDIS 2003 Key Measures

Standard HEDIS 2003 Measure	2003 MDCH Key Measures
1. Childhood Immunization Status	1. Childhood Immunization Status – Combination #1 2. Childhood Immunization Status – Combination #2
2. Adolescent Immunization Status	3. Adolescent Immunization Status – Combination #1 4. Adolescent Immunization Status – Combination #2
3. Well-Child Visits in the First 15 Months of Life	5. Well-Child Visits in the First 15 Months of Life – Zero Visits 6. Well-Child Visits in the First 15 Months of Life – Six or More Visits
4. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	7. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
5. Adolescent Well-Care Visits	8. Adolescent Well-Care Visits
6. Breast Cancer Screening	9. Breast Cancer Screening
7. Cervical Cancer Screening	10. Cervical Cancer Screening
8. Chlamydia Screening in Women	11. Chlamydia Screening in Women – Ages 16 to 20 Years 12. Chlamydia Screening in Women – Ages 21 to 26 Years 13. Chlamydia Screening in Women – Combined Rate
9. Prenatal and Postpartum Care	14. Prenatal and Postpartum Care – Timeliness of Prenatal Care 15. Prenatal and Postpartum Care – Postpartum Care
10. Comprehensive Diabetes Care	16. Comprehensive Diabetes Care – HbA1c Testing 17. Comprehensive Diabetes Care – Poor HbA1c Control 18. Comprehensive Diabetes Care – Eye Exam 19. Comprehensive Diabetes Care – LDL-C Screening 20. Comprehensive Diabetes Care – LDL-C Level 21. Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy
11. Use of Appropriate Medications for People with Asthma	22. Use of Appropriate Medications for People with Asthma – Ages 5 to 9 Years 23. Use of Appropriate Medications for People with Asthma – Ages 10 to 17 Years 24. Use of Appropriate Medications for People with Asthma – Ages 18 to 56 Years 25. Use of Appropriate Medications for People with Asthma – Combined Rate
12. Controlling High Blood Pressure	26. Controlling High Blood Pressure
13. Medical Assistance with Smoking Cessation*	27. Advising Smokers to Quit*
14. Children's Access to Primary Care Practitioners	28. Children's Access to Primary Care Practitioners – Ages 12 to 24 Months 29. Children's Access to Primary Care Practitioners – Ages 25 Months to 6 Years 30. Children's Access to Primary Care Practitioners – Ages 7 to 11 Years
15. Adults' Access to Preventive/ Ambulatory Health Services	31. Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years 32. Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years 33. Adults' Access to Preventive/Ambulatory Health Services – Ages 65+

* The *Medical Assistance With Smoking Cessation – Advising Smokers to Quit* measure was previously known as *Advising Smokers to Quit*.

Key Measure Audit Designations

Through the audit process, each measure reported by a health plan is assigned an NCQA-defined audit designation. Measures can receive one of two predefined designations: *Report* or *Not Report*. An audit designation of:

- *Report* indicates that the health plan complied with all HEDIS specifications to produce an unbiased, reportable rate or rates, which can be released for public reporting.
- *Not Report* indicates that the rate will not be publicly reported.

A subset of the *Report* designation is the *Not Applicable* assignment to a rate. Although a health plan may have complied with all applicable specifications, the denominator identified may be considered too small (less than 30) to report a rate. In this case, the measure is assigned a *Report* designation with a *Not Applicable* rate.

It should be noted that NCQA allows health plans to "rotate" HEDIS measures in some circumstances. The rotation schedule enables health plans to use audited and reportable rates from the previous year. This strategy allows health plans with higher rates for some measures to expend resources toward improving rates for other measures. Only hybrid measures are eligible to be rotated; they must also have (a) been audited in the previous year and (b) received a *Report* audit designation.

Michigan Medicaid health plans that met the HEDIS criteria for hybrid measure rotation could exercise that option if they chose to do so. In 2003, two health plans chose to rotate measures and a total of six rates were rotated. In keeping with NCQA methodology, rotated measures were assigned their respective 2002 reported rates and were included in the calculations for the Michigan Medicaid weighted averages.

Dimensions of Care

HSAG examined four different dimensions of care for Michigan Medicaid members:

1. Pediatric Care
2. Women's Care
3. Living with Illness
4. Access to Care

These dimensions reflect important groupings similar to the dimensions model used by FACCT. This approach to the analysis is designed to encourage health plans to consider the Key Measures as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

Changes to Measures

NCQA made two changes for reporting year 2003 to the Key Measure, *Advising Smokers to Quit*. First, the measure was renamed *Medical Assistance With Smoking Cessation*, and was revised to include three separate rates, listed below:

- *Advising Smokers to Quit*
- *Discussing Smoking Cessation Medications*
- *Discussing Smoking Cessation Strategies*

Second, the methodology to calculate the rate for *Advising Smokers to Quit* changed. The measure is now calculated using a rolling average. Rates are reported using data from the most recent two reporting years, with the rolling average of 2002 and 2003 included in this report. Since this is the first time the two-year rolling average for *Medical Assistance With Smoking Cessation — Advising Smokers to Quit* is reported, comparison with 2002 data alone is not valid. Trending data will be shown in 2004, when the rolling average of 2003 and 2004 is also available for comparison.

Performance Levels

The purpose of identifying performance levels is to compare the quality of services provided to Michigan Medicaid enrollees and ultimately improve the Michigan Medicaid average for all the Key Measures. Two levels have been established for each Key Measure at specific attainable rates:

- The High Performance Level (HPL) represents current high performance in national Medicaid managed care.
- The Low Performance Level (LPL) represents below average performance nationally.

Health plans should focus their efforts on reaching and maintaining the HPL for each Key Measure, rather than comparing themselves to other Michigan Medicaid health plans.

Comparative information in this report is based on the national HEDIS 2002 Medicaid percentiles, which are the most recent results available from NCQA. For most Key Measures included in this report:

- The 90th percentile indicates the HPL.
- The 25th percentile indicates the LPL.
- Average performance falls between the LPL and the HPL.

According to this performance level scheme, Michigan Medicaid health plans with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all Medicaid health plans nationally. Similarly, health plans reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

This performance level scheme is reversed for two of the Key Measures:

1. *Well-Child Visits in the First 15 Months of Life – Zero Visits*, for which the lower rates of **no** visits indicate better care.
2. *Comprehensive Diabetes Care – Poor HbA1c Control*, for which the lower rates of **poor** control indicate better care.

For these two Key Measures only, *lower* rates indicate better performance:

- The 10th percentile (rather than the 90th) shows excellent performance and represents the HPL.
- The 75th percentile (rather than the 25th) shows below average performance and represents the LPL.

This report identifies and specifies the number of Michigan Medicaid health plans with HPL, LPL, and average performance levels.

Performance Star Ratings

For each dimension of care, a performance summary figure shows results for all Michigan Medicaid health plans. Results were calculated using a scoring algorithm based on individual health plan performance relative to the HPL, LPL, and national HEDIS 2002 Medicaid 50th percentile.

For each health plan, points were summed across all measures in the dimension and then averaged by the number of measures in that dimension. Fractions of 0.5 or greater were rounded up to the next whole number. *Not Applicable* ("NA") designations were not included in the denominator.

These results are presented in this report using a star system assigned as follows:

- Three stars (★★★) for performance at or above the HPL.
- Two stars (★★) for performance above the LPL but below the HPL.
- One star (★) for performance at or below the LPL, or for *Not Report* ("NR") designations.

Not Applicable designations are shown as "NA."

Michigan Medicaid Averages

The principal measure of overall Michigan Medicaid performance on a given Key Measure is the *weighted* average rate. The use of a weighted average, based on the health plan's eligible population for that measure, provides the most representative rate for the overall Michigan Medicaid population. Weighting the rate by the health plan eligible population size ensures that rates for a health plan with 125,000 members, for example, have a greater impact on the overall Michigan Medicaid rate than do the rates for a health plan with 10,000 members.

Interpreting and Using Reported Averages and Aggregate Results

The 2003 Michigan Medicaid Weighted Average was computed by HSAG based on the reported rates and weighted by the reported eligible population size for that measure. This is a better estimate of care for all of Michigan's Medicaid enrollees, rather than the average performance of Michigan Medicaid health plans.

The 2003 Michigan Medicaid aggregate results, which illustrate how much of the final rate is derived from administrative data and how much from medical record review, is not an average. It is the sum of all numerator events divided by the sum of all the denominators across all the reporting health plans for a given measure.

Example

For example, three health plans in a given state reported for a particular measure:

- Health Plan A used the administrative method and had 6,000 numerator events out of 10,000 members in the denominator (60 percent).
- Health Plan B also used the administrative method and found 5,000 numerator events out of 15,000 members (33 percent).
- Health Plan C used the hybrid methodology and had 8,000 numerator events (1,000 of which came from medical record abstraction) and had 16,000 members in the denominator (50 percent).
- There are a total of 41,000 members across health plans.
- There are 19,000 numerator events across health plans, 18,000 from administrative data, and 1,000 from medical record abstraction.
- The rates are as follows:
  - The overall aggregate rate is 46 percent (or 19,000/41,000).
  - The administrative aggregate rate is 44 percent (or 18,000/41,000).
  - The medical review rate is 2 percent (or 1,000/41,000).

Significance Testing

In this report, differences between the 2002 and 2003 Michigan Medicaid weighted averages have been analyzed using a t-test to determine if the change was statistically significant. The t-test evaluates the differences between mean values of two groups, relative to the variability of the distribution of the scores. The t-value generated is used to judge how likely it is that the difference is real and not the result of chance.

To determine the significance for this report, a risk level of 0.05 was selected. This risk level, or *alpha level*, means that 5 times out of 100 we may find a statistically significant difference between the mean values even if none actually existed (that is, it happened "by chance"). All comparisons between the 2002 and 2003 Michigan Medicaid weighted averages reported as statistically significant in this report are significant at the 0.05 level.

Calculation Methods: Administrative Versus Hybrid

Administrative Method

The administrative method of calculating performance for a Key Measure requires health plans to use *only* administrative data:

- To identify the population of individuals eligible to receive the relevant service. This number is the denominator.
- To identify members in the eligible population who received each of the relevant service. This number is the numerator.

Medical records cannot be used to retrieve this information, and sampling is not allowed.

In three of the four dimensions of care in this report—Women's Care, Living with Illness and Access to Care —there are measures where HEDIS methodology requires that the rates be derived using only the administrative method and medical record review is not permitted. These are:

- *Chlamydia Screening in Women – all age groups*
- *Use of Appropriate Medications for People with Asthma – all age groups*
- *Children's Access to Primary Care Practitioners – all age groups*
- *Adults' Access to Preventive/Ambulatory Health Services – all age groups*

The administrative method is cost efficient, but it can produce lower rates if there is incomplete data submission by capitated providers.

Hybrid Method

The hybrid method requires health plans to:

1. Use administrative data to identify the eligible population.
2. Extract a systematic sample of 411 members from the eligible population. This number is the denominator.
3. Use administrative data to identify the number of members in the denominator who received the relevant service.
4. For the other members (from the sample of 411) whose administrative data did *not* show evidence that the relevant service was provided, review the medical records to identify those who *did*, in fact, receive the service.
5. The sum of the numbers from steps 3 and 4 above is the numerator.

The hybrid method generally produces higher results, but it is considerably more labor intensive.

Example Using Both Methods

The following example illustrates how these two methods can produce significantly different rates.

A health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure.

- Using the **administrative method**, the health plan finds that 4,000 members out of the 10,000 had evidence from administrative data of a postpartum visit. The final rate for this measure, using the administrative method, would therefore be 4,000/10,000 (40 percent).

- Using the **hybrid method**, the health plan randomly selects 411 eligible members and finds from administrative data that 161 of these 411 members had evidence of a postpartum visit. The health plan then obtains and reviews medical records for the 250 members who did not have evidence from administrative data of a postpartum visit. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would therefore be (161 + 54) /411 (52 percent).

Interpreting Results

As expected, HEDIS results can differ to a greater or lesser extent among health plans and even across measures for the same health plan.

Four questions should be asked when examining these data:

1. How accurate are the results?
2. How do Michigan Medicaid rates compare to national percentiles?
3. How are Michigan Medicaid health plans performing overall?
4. Can the health plans do a better job calculating the measures?

The next paragraphs address these questions and explain the methods used in this report to present the results for clear, easy, and accurate interpretation.

1. How accurate are the results?

All Michigan Medicaid health plans are required by MDCH to have their HEDIS results confirmed by an NCQA HEDIS Compliance Audit™. As a result, any rate included in this report has been verified as an unbiased estimate of the measure. The NCQA HEDIS protocol is designed so that the hybrid method produces results with a sampling error of ± 5 percent at a 95 percent confidence level.

How sampling error affects accuracy of results is best explained using an example. Suppose a health plan uses the hybrid method to derive a *Postpartum Care* rate of 52 percent. Because of sampling error, the *true* rate is actually ± 5 percent of this rate—somewhere between 47 percent and 57 percent at a 95 percent confidence level. If the target is a rate of 55 percent, it cannot be said with certainty whether the true rate between 47 percent and 57 percent meets or does not meet the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. For internal purposes, health plans should understand and consider the issue of sampling error when implementing interventions.

More information is provided in “Understanding Sampling Error” on page 2-8.

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2. How do Michigan Medicaid rates compare to national percentiles?

For each measure, a health plan ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS 2002 Medicaid 50th percentile. In addition, the 2003 and 2002 Michigan Medicaid weighted averages are presented for comparison purposes.

Michigan Medicaid health plans with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all Medicaid health plans nationally. Similarly, health plans reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

3. How are Michigan Medicaid health plans performing overall?

For each dimension, a performance profile analysis compares the 2003 Michigan Medicaid weighted average for each rate with the 2002 Michigan Medicaid weighted average and the national HEDIS 2002 Medicaid 50th percentile.

4. Can the health plans do a better job of calculating the measures?

For each rate, a data collection analysis shows the number of health plans using each methodology (hybrid or administrative). For all except the administrative-only measures, the proportion of each reported rate resulting from administrative data and the proportion resulting from medical record review are displayed in a stacked bar. Columns to the right of the stacked bar show precisely how much of the final rate was derived from the administrative method and how much from medical record review. Because of rounding differences, the sum of the administrative rate and the medical record review rate may not always be exactly equal to the final rate.

The Michigan 2003 aggregate bar represents the sum of all administrative events and medical record review events for all members in the statewide denominator, regardless of the data collection methodology used.

In addition, Section 7 of this report discusses systemic issues facing the Michigan Medicaid health plans. Process issues are identified, and recommendations for improvement are made.

Understanding Sampling Error

Correct interpretation of results for measures collected using the HEDIS hybrid method requires an understanding of sampling error. It is rarely possible logistically or financially to do medical record review for the entire eligible population for a given measure. Key Measure data collected using the HEDIS hybrid method include only a sample from the population and use statistical techniques to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire population, the process of sample selection requires that everyone in the eligible population have an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process selecting 411 members of the eligible population. Health plans may use a 5 percent, 10 percent, 15 percent, or 20 percent over-sample to replace invalid cases (for example, a male selected for *Postpartum Care*). If a health plan has fewer than 411 valid cases in the eligible population, then the entire eligible population is selected.

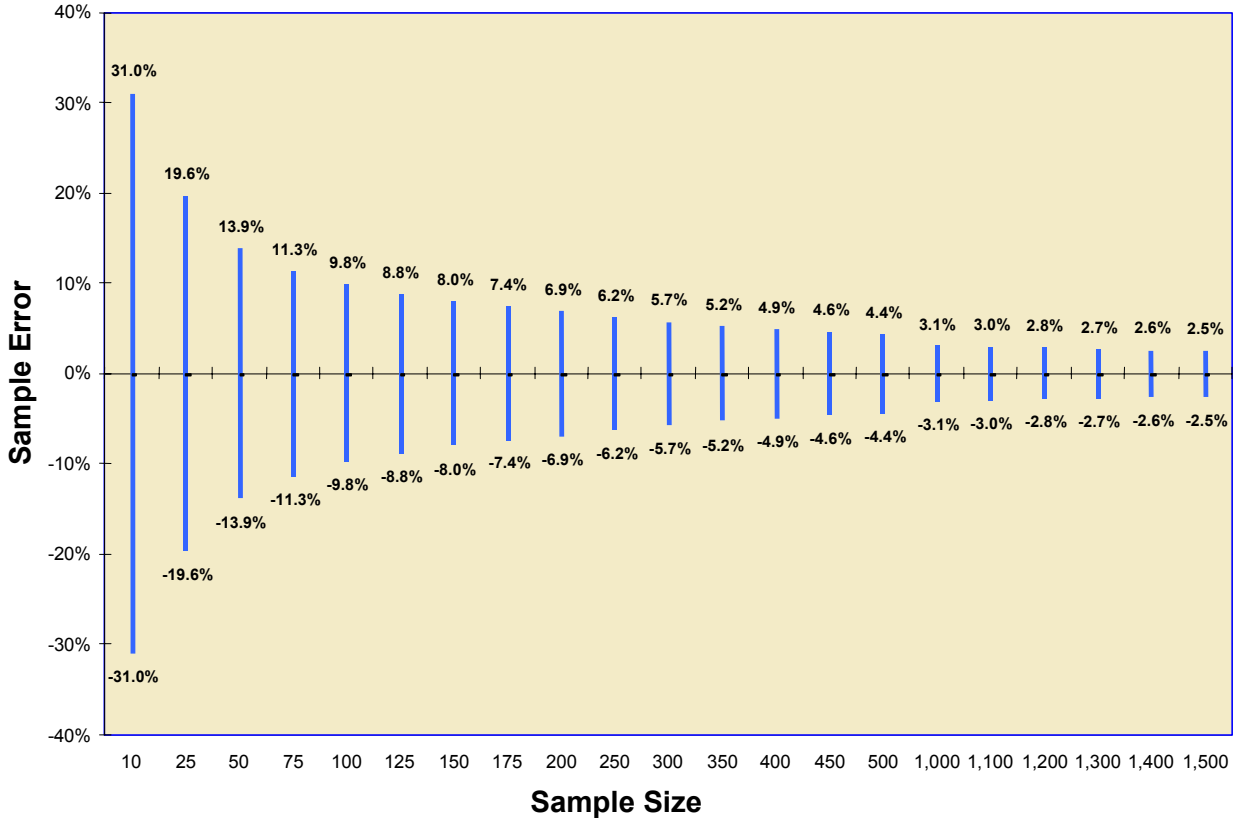
Figure 2-1 on page 2-9 shows that, if 411 health plan members are included in a measure, the margin of error is approximately ± 4.9 percent. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000.

As the figure shows:

- Sampling error gets smaller as sample size gets larger.
- Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant.
- However, not all statistically significant differences are important.
- Nevertheless, the difference between two measured rates may not be statistically significant but may still be important.

These points underscore the fact that the judgment of the reviewer is always essential for meaningful data interpretation.

Figure 2-1—Relationship of Sample Size to Sampling Error



Health Plan Names and Codes

The following sections of this report contain figures that show overall health plan performance for each of the Key Measures.

Table 2-2 below lists the full names and corresponding three-letter codes used to identify the health plans in the figures.

Table 2-2—2003 Michigan Medicaid Health Plan Names and Codes

Code	Full Name
BOT	Botsford Health Plan
CAP	Cape Health Plan
CCM	Community Choice Michigan
CCP	Community Care Plan
GLH	Great Lakes Health Plan
HPM	Health Plan of Michigan
HPP	HealthPlus Partners
MCD	M-CAID
MCL	McLaren Health Plan
MID	Midwest Health Plan
MOL	Molina Healthcare of Michigan
OCH	OmniCare Health Plan
PMD	Physician's Health Plan of Mid-Michigan Family Care
PRI	Priority Health Government Programs
PSW	Physician's Health Plan of Southwest Michigan
THC	Total Health Care
TWP	The Wellness Plan
UPP	Upper Peninsula Health Plan

3. Pediatric Care

Introduction

Michigan Medicaid provides care to more than 730,500 children from birth through 19 years of age.[3-1] Pediatric primary health care is essential to prevention, recognition, and treatment of health conditions that could have significant developmental consequences for children and adolescents. The need for appropriate immunizations and health check-ups has even greater importance and significance at younger ages. For example, abnormalities in growth, hearing, and vision undetected in toddlers impact all future learning opportunities and experiences. Early detection of developmental difficulties provides the greatest opportunity for intervention and resolution so that children continue to grow and learn free from any health-related limitations.

Healthy People 2010 set a national goal of enrolling 95 percent of children from birth through age 5 in an immunization registry.[3-2] The nationally recognized Michigan Childhood Immunization Registry (MCIR) provides health care providers with access to immunization records and allows them to more effectively identify children who are behind in their immunizations. All health care providers in the State of Michigan who provide immunization services to a child born after December 31, 1993, are required to report each immunization to the registry. Since 1996, the electronic database has grown to include more than 27 million vaccinations provided for 2.6 million Michigan children, with provider participation increasing at a rate of approximately 5 percent per month.[3-3] Recently, the Centers for Disease Control and Prevention's National Immunization Survey noted improvement in Michigan immunization rates and ranked Michigan sixth in the nation for the percentage of children vaccinated against deadly diseases.[3-4]

The following pages provide detailed analysis of Michigan Medicaid health plans' performance, ranking, and the data collection methodology used for these measures.

The Pediatric Care dimension encompasses the following MDCH Key Measures:

- **Childhood Immunization Status**
  - *Childhood Immunization Status – Combination #1*
  - *Childhood Immunization Status – Combination #2*
- **Adolescent Immunization Status**
  - *Adolescent Immunization Status – Combination #1*
  - *Adolescent Immunization Status – Combination #2*
- **Well-Care Visits**
  - *Well-Child Visits in the First 15 Months of Life – Zero Visits*
  - *Well-Child Visits in the First 15 Months of Life – Six or More Visits*
  - *Well-Child Visits in the Third, Fourth, Fifth Years of Life*
  - *Adolescent Well-Care Visits*

[3-1] State of Michigan. Michigan Department of Community Health. Enrollment Services. Section Report BN-271. Run Date May 1, 2003.
[3-2] Healthy People 2010: Objectives for Improving Health. Available at: http://www.healthypeople.gov/Document/HTML\Volume1\14Immunization.htm. Accessed October 10, 2003.
[3-3] Michigan Public Health Institute. 2001 Michigan Childhood Immunization Registry. Available at: http://www.mcir.org/pro_accomp.htm. Accessed October 10, 2003.
[3-4] State of Michigan. Michigan Department of Community Health. Available at http://www.michigan.gov/mdch. August 1, 2003.

Childhood Immunization Status

Over the last 50 years, childhood vaccination has led to dramatic declines to many life-threatening diseases such a polio, tetanus, whooping cough, mumps, measles, and meningitis. However, in the United States, more than 20 percent of 2-year-olds are still missing one or more recommended immunizations.[3-5]

Adequate vaccination coverage for measles and other infectious diseases is important in preventing a widespread resurgence of vaccine-preventable diseases in the United States. Overall, the state of Michigan has made notable progress in improving childhood immunization. Eighty-nine percent of children have two or more doses recorded in the Michigan Childhood Immunization Registry (MCIR), while the national average for registries is 24 percent.[3-6]

Key Measures in this section include:

- *Childhood Immunization Status – Combination #1*
- *Childhood Immunization Status – Combination #2*

These are commonly referred to as *Combo 1* and *Combo 2*.

HEDIS Specification: Childhood Immunization Status – Combination #1

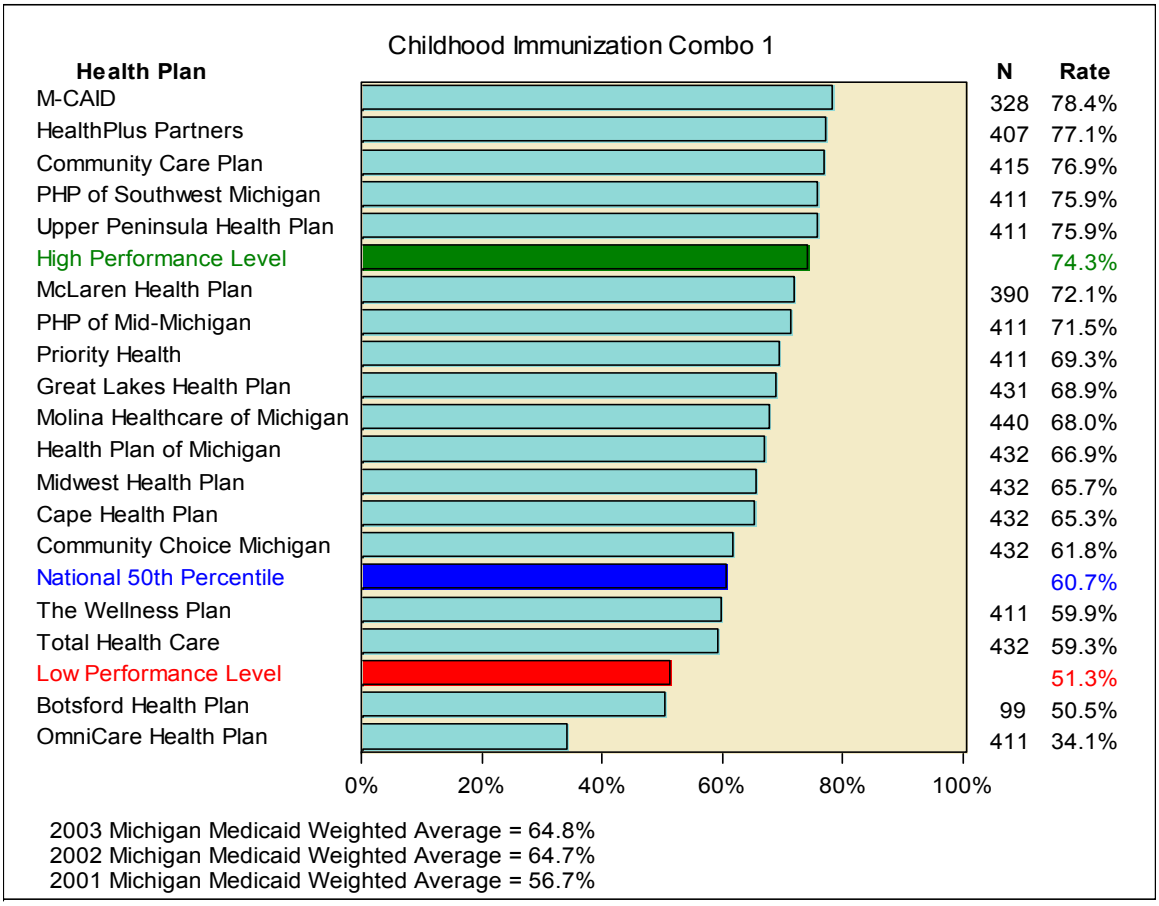
The measure *Childhood Immunization Status – Combination #1* calculates the percentage of enrolled children who (a) turned two years old during the measurement year, (b) were continuously enrolled for 12 months immediately preceding their second birthday, and (c) were identified as having four DtaP/DT, three IPV/OPV, one MMR, three *H influenzae* type b, and three hepatitis B vaccinations each within the allowable time period and by their second birthday.

[3-5] National Committee for Quality Assurance. *The State of Health Care Quality 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance: 2003, p.30.

[3-6] Michigan Public Health Institute. Information for Providers: Accomplishments. 2001 Michigan Childhood Immunization Registry. Available at: http://www.mcir.org/pro_accomp.htm. Accessed on October 10, 2003.

Health Plan Ranking: Childhood Immunization Status – Combination #1

Figure 3-1—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Childhood Immunization Status – Combination #1

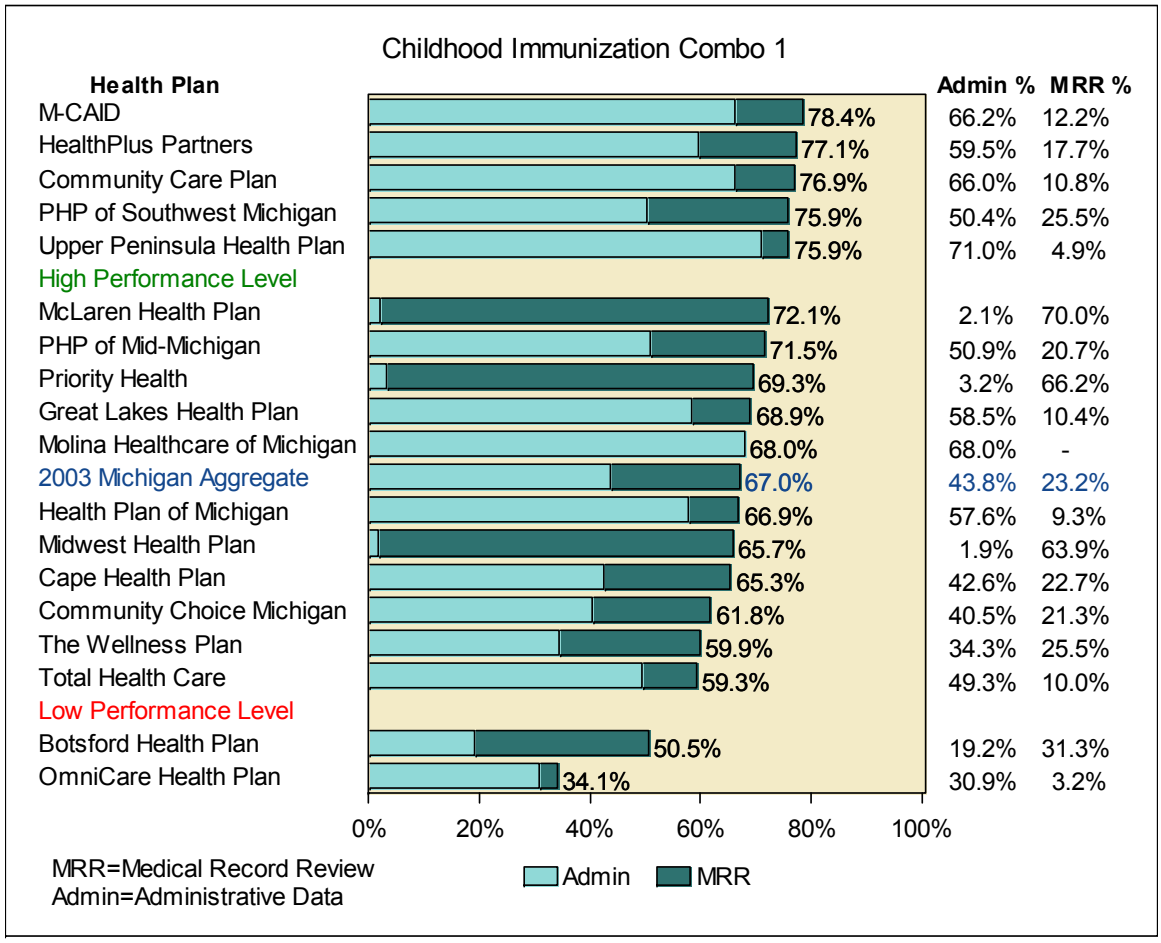


Five of the health plans had reported rates above the HPL, whereas two health plans had rates below the LPL. A total of 14 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 64.8 percent was higher than the national HEDIS 2002 Medicaid 50th percentile rate of 60.7 percent and just above the 2002 Michigan Medicaid weighted average of 64.7 percent. The Michigan Medicaid weighted average gain in 2003, of 0.1 percentage points, was not statistically significant. The 18 reported rates ranged from 34.1 percent to 78.4 percent. Denominator sizes ranged from 99 to 440.

Data Collection Analysis: Childhood Immunization Status – Combination #1

Figure 3-2—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Childhood Immunization Status – Combination #1



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates except Molina Healthcare of Michigan elected to use hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate was 43.8 percent and the medical record review rate was 23.2 percent.

This result demonstrates that, overall, 65.4 percent of the aggregate rate was derived from administrative data and 34.6 percent from medical record review. Last year, 54.8 percent of the aggregate rate was derived from administrative data.

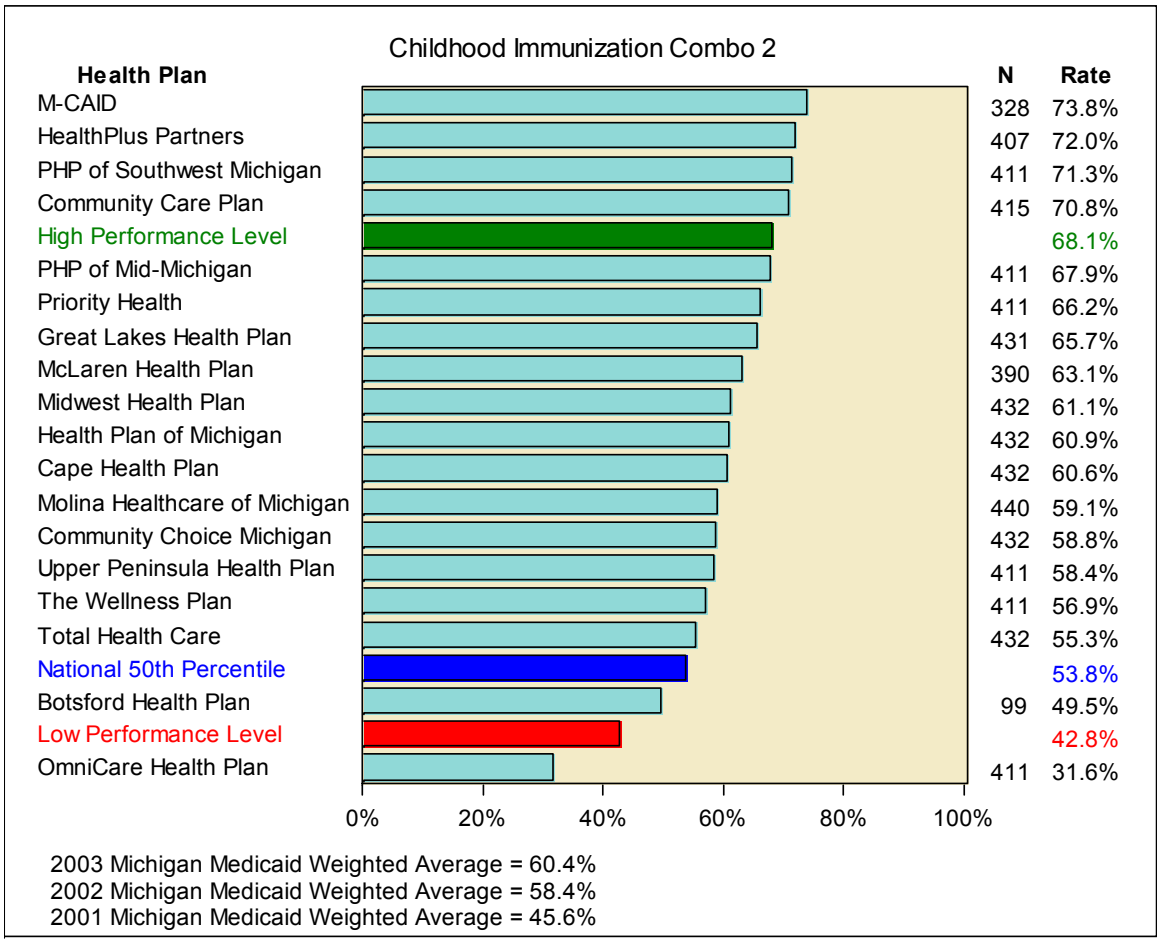
While the top performing health plan, M-CAID, derived 84 percent of its rate from administrative data, three health plans (McLaren Health Plan, Priority Health Government Programs, and Midwest Health Plan) derived less than 5 percent of their rates from administrative data. This disparity seems to highlight differences in health plan use of the MCIR as an administrative resource. HSAG recommends that MDCH encourage health plans to redirect resources to improving use of the MCIR, reducing reliance on resource-intensive medical record review.

HEDIS Specification: Childhood Immunization Status – Combination #2

The measure *Childhood Immunization Status – Combination #2* reports the percentage of enrolled children who (a) turned two years old during the measurement year, (b) were continuously enrolled for 12 months immediately preceding their second birthday, and (c) were identified as having all the vaccines listed for *Combination #1* and at least one chickenpox (varicella-zoster virus, or VZV) vaccination by their second birthday.

Health Plan Ranking: Childhood Immunization Status – Combination #2

Figure 3-3—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Childhood Immunization Status – Combination #2

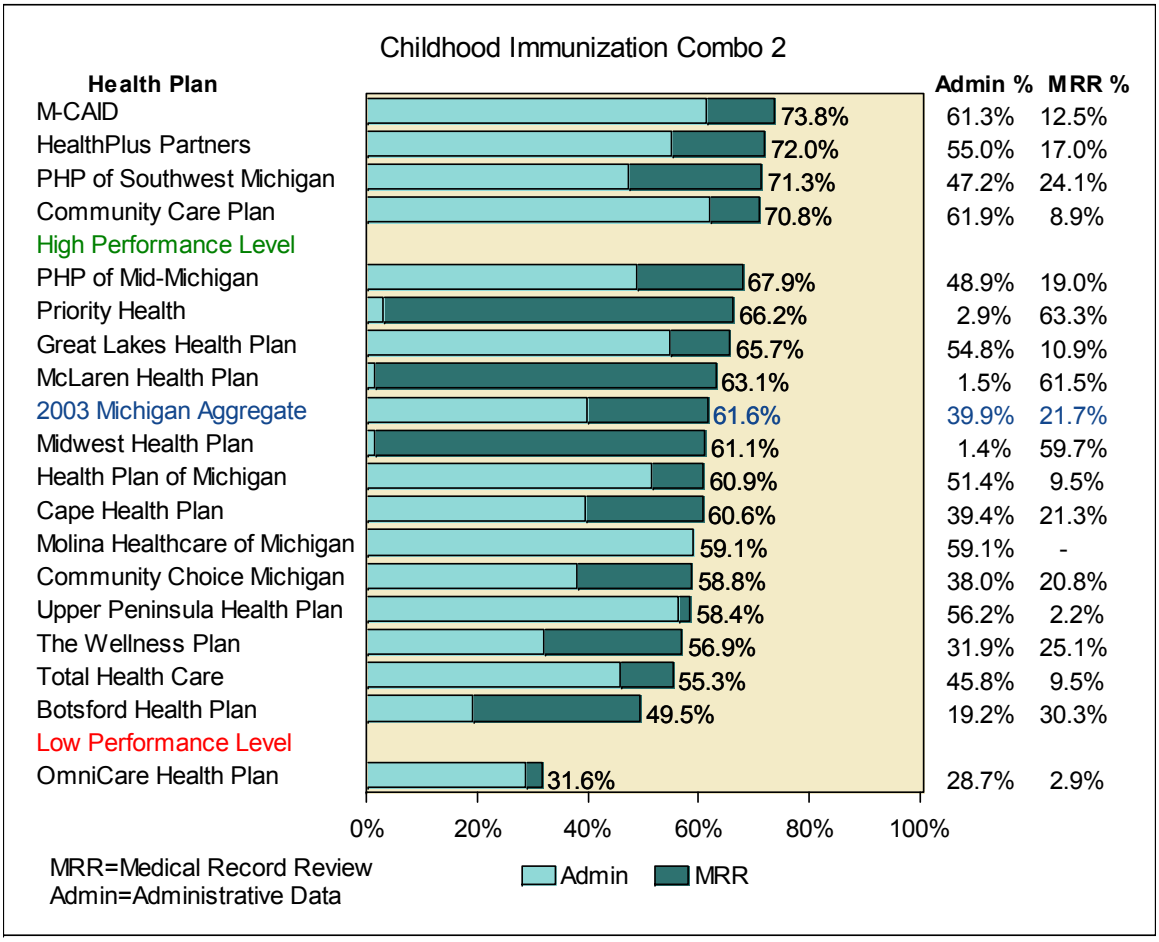


Four of the health plans had reported rates above the HPL, while one health plan (OmniCare Health Plan) had a rate below the LPL. A total of 16 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 60.4 percent was higher than both the national HEDIS 2002 Medicaid 50th percentile rate of 53.8 percent and the 2002 Michigan Medicaid weighted average of 58.4 percent. The Michigan Medicaid weighted average gain in 2003, of 2.0 percentage points, was not statistically significant. The 18 reported rates ranged from 31.6 percent to 73.8 percent. Denominator sizes ranged from 99 to 440.

Data Collection Analysis: Childhood Immunization Status – Combination #2

Figure 3-4—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Childhood Immunization Status – Combination #2



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates except Molina Healthcare of Michigan elected to use hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate was 39.9 percent and the medical record review rate was 21.7 percent.

This result demonstrates that, overall, 64.8 percent of the aggregate rate was derived from administrative data and 35.2 percent from medical record review. Last year, 54.1 percent of the aggregate rate was derived from administrative data.

Fifteen health plans derived more than half of their rate from administrative data while three health plans (McLaren Health Plan, Priority Health Government Programs, and Midwest Health Plan) derived less than 5 percent of their rates from administrative data.

Adolescent Immunization Status

In the United States, immunization programs that focus on infants and children have decreased the occurrence of many vaccine-preventable diseases. However, adolescents and young adults continue to be adversely affected by vaccine-preventable diseases (e.g., varicella, hepatitis B, measles, and rubella), partly because many immunization programs have placed less emphasis on improving vaccination coverage among adolescents.

Each year, more than 70 percent of the estimated 125,000 new cases of hepatitis B affect adolescents and young adults.[3-7] Immunizations effectively and efficiently reduce the occurrence of harmful and costly diseases. For every dollar spent, savings can range from $2.20 for hepatitis B to as high as $13 for the MMR vaccine.[3-8]

Key Measures in this section include:

- *Adolescent Immunization Status – Combination #1*
- *Adolescent Immunization Status – Combination #2*

These are commonly referred to as *Combo 1* and *Combo 2*.

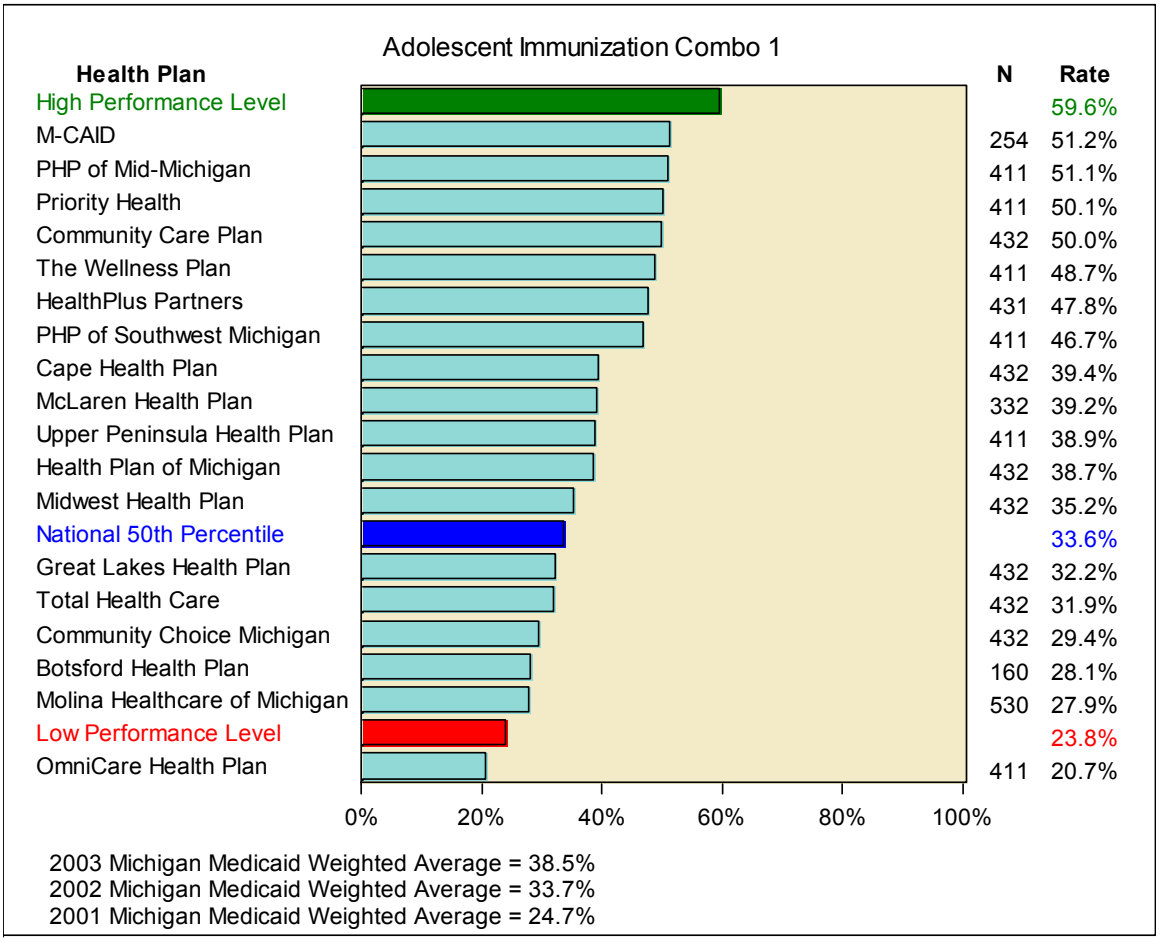
HEDIS Specification: Adolescent Immunization Status – Combination #1

Adolescent Immunization Status – Combination #1 calculates the percentage of enrolled adolescents who (a) turned 13 years old during the measurement year, (b) were continuously enrolled for 12 months immediately preceding their thirteenth birthday, and (c) were identified as having had a second dose of MMR and three hepatitis B vaccinations by their thirteenth birthday.

[3-7] National Committee for Quality Assurance. *The State of Managed Care Quality. 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance: 2003, p.23.
[3-8] Iowa Department of Public Health. "Ch. 10: Immunization and Infectious Diseases," *Healthy Iowans 2010.*

Health Plan Ranking: Adolescent Immunization Status – Combination #1

Figure 3-5—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Adolescent Immunization Status – Combination #1

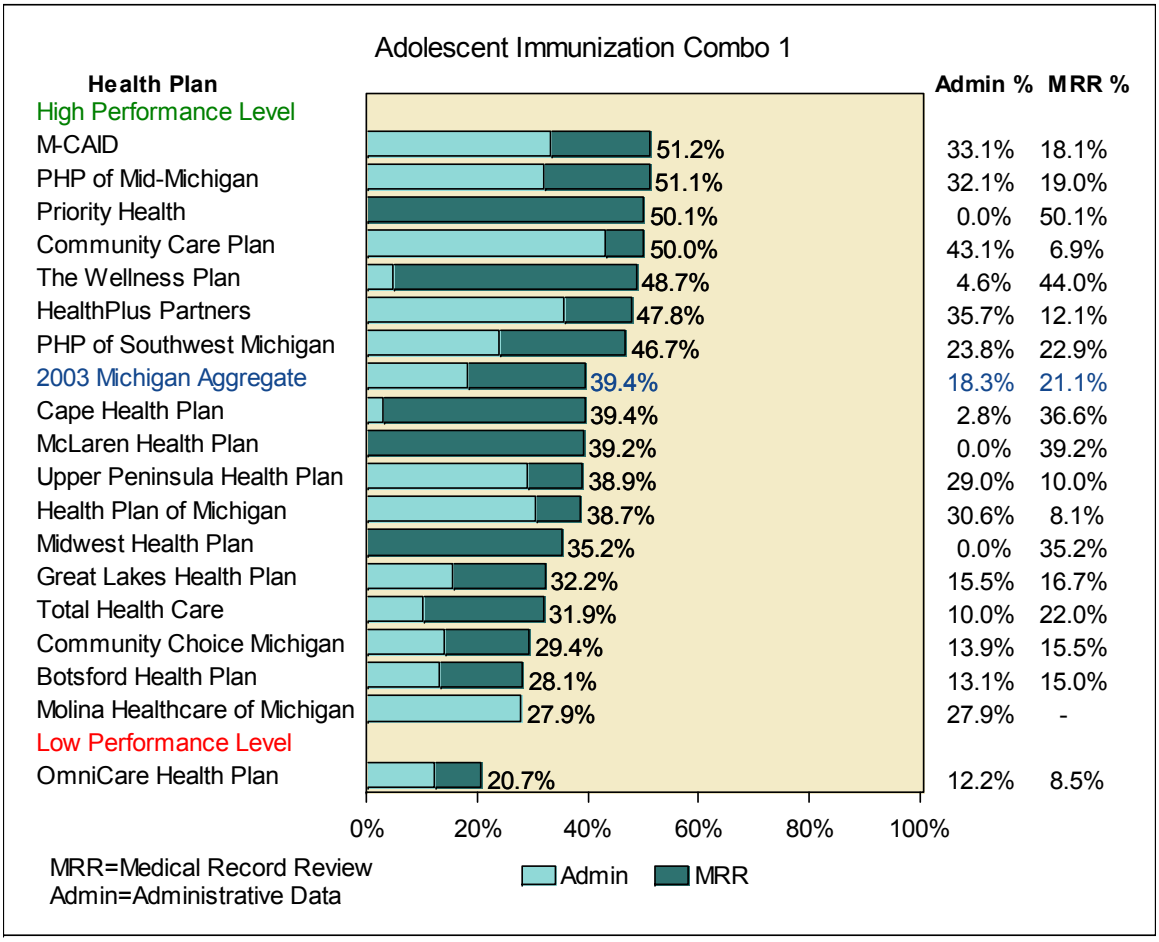


None of the health plans had reported rates above the HPL, while one health plan (OmniCare Health Plan) had a rate below the LPL. A total of 12 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 38.5 percent was higher than both the national HEDIS 2002 Medicaid 50th percentile rate of 33.6 percent and the 2002 Michigan Medicaid weighted average of 33.7 percent. The Michigan Medicaid weighted average gain in 2003, of 4.8 percentage points, was not statistically significant. The 18 reported rates ranged from 20.7 percent to 51.2 percent. Denominator sizes ranged from 160 to 530.

Data Collection Analysis: Adolescent Immunization Status – Combination #1

Figure 3-6—Michigan Medicaid HEDIS 2003 Data Collection Analysis: Adolescent *Immunization Status – Combination #1*



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates except Molina Healthcare of Michigan elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate was 18.3 percent and the medical record review rate was 21.1 percent.

This result demonstrates that, overall, 46.4 percent of the aggregate rate was derived from administrative data and 53.6 percent from medical record review. Last year, 36.2 percent of the aggregate rate was derived from administrative data.

Although nine health plans derived more than half of their rate from administrative data, another three health plans had no administrative hits, with all of the final rate derived from medical record review.

HEDIS Specification: Adolescent Immunization Status – Combination #2

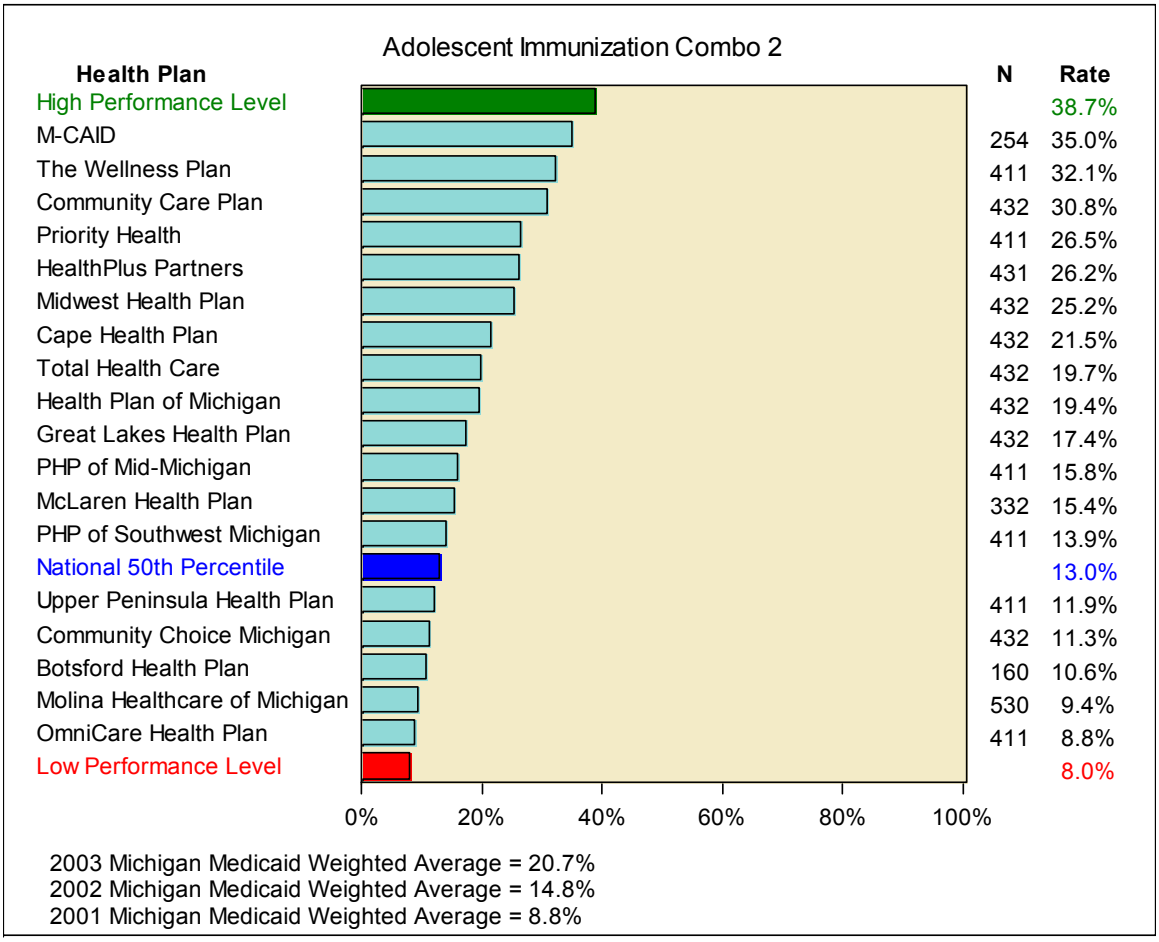
Adolescents are 10 times more likely than younger children to develop serious complications from varicella zoster virus, commonly known as "chicken pox." The rate of complications is greatest for those individuals aged 15 or older, yet a significant number of teens still do not receive VZV vaccinations.[3-9]

The measure *Adolescent Immunization Status – Combination #2* calculates the percentage of enrolled adolescents who (a) turned 13 years old during the measurement year, (b) were continuously enrolled for 12 months immediately preceding their thirteenth birthday, and (c) were identified as having had all the vaccinations listed in *Combination #1* and at least one VZV vaccination by their thirteenth birthday.

[3-9] National Committee for Quality Assurance. *The State of Managed Care Quality, 2001* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2001:26.

Health Plan Ranking: Adolescent Immunization Status – Combination #2

Figure 3-7—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Adolescent Immunization Status – Combination #2

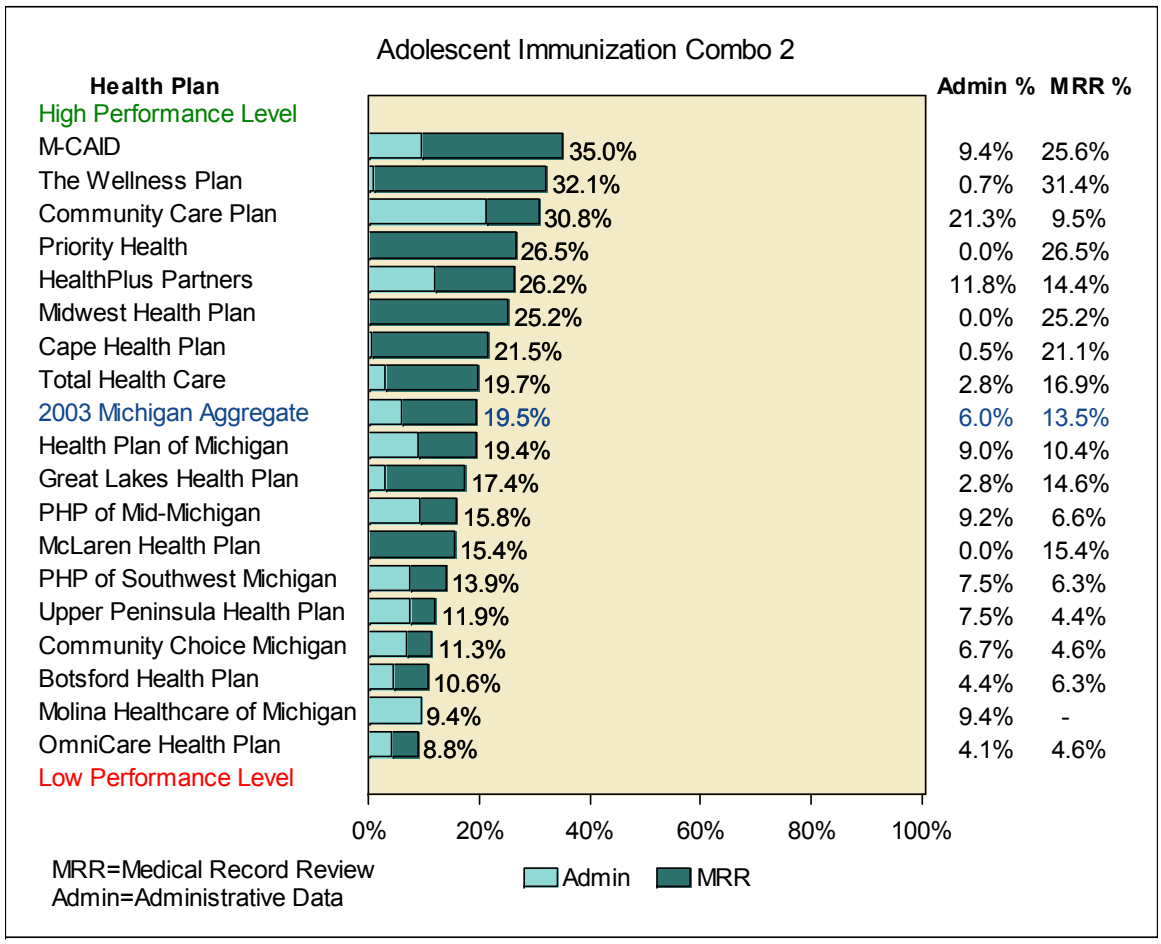


All of the health plans had reported rates between HPL and LPL. A total of 13 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 20.7 percent was higher than the national HEDIS 2002 Medicaid 50th percentile rate of 13.0 percent. The 2003 Michigan Medicaid weighted average showed a statistically significant gain over 2002 of 5.9 percentage points, increasing from 14.8 percent to 20.7 percent. The 18 reported rates ranged from 8.8 percent to 35.0 percent. Denominator sizes ranged from 160 to 530.

Data Collection Analysis: Adolescent Immunization Status – Combination #2

Figure 3-8—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Adolescent Immunization Status – Combination #2



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates except Molina Healthcare of Michigan elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate was 6.0 percent and the medical record review rate was 13.5 percent.

This result demonstrates that, overall, 30.8 percent of the aggregate rate was derived from administrative data and 69.2 percent from medical record review. Last year, 16.0 percent of the aggregate rate was derived from administrative data.

Only six health plans derived more than half of their rate from administrative data, while three health plans had no administrative hits, with all of the final rate derived from medical record review.

Well-Child Visits in the First 15 Months of Life

The American Medical Association (AMA), the federal government's Bright Future program, and the American Academy of Pediatrics (AAP) all recommend comprehensive periodic well-child visits for children. These periodic checkups provide opportunities for addressing the physical, emotional, and social aspects of their health. These well-child visits provide opportunities for the primary care providers to detect physical, developmental, behavioral, and emotional problems and provide early interventions and treatment and appropriate referrals to specialists. It is also recommended that clinicians use these visits to offer counseling and guidance to parents.

Michigan Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements specify the components of age-appropriate well-child visits. The required components include: review of child's clinical history and immunization status, measuring height and weight, sensory screening, developmental assessment, anticipatory guidance, nutritional assessment, and procedures such as lead testing, TB testing, etc. Without these visits, children are at much greater risk of reaching their teens with developmental problems that have not been addressed.

Key Measures include the following rates:

- *Well-Child Visits in the First 15 Months of Life – Zero Visits*
- *Well-Child Visits in the First 15 Months of Life – Six or More Visits*

The following pages analyze in detail the performance profile, health plan rankings, and data collection methodology used by the Michigan Medicaid health plans for the two rates reported for this Key Measure: *Zero Visits* and *Six or More Visits*.

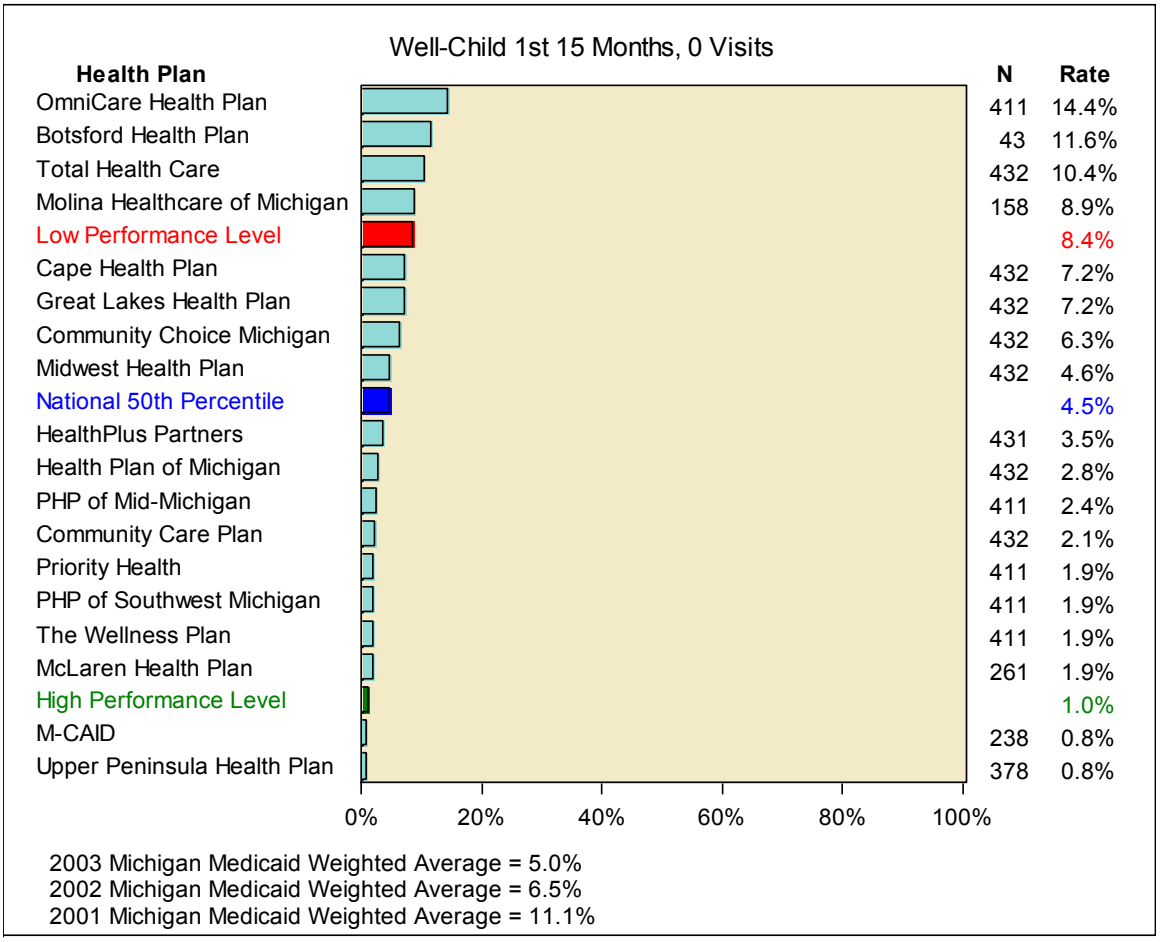
HEDIS Specification: Well-Child Visits in the First 15 Months of Life – Zero Visits

Well-Child Visits in the First 15 Months of Life – Zero Visits calculates the percentage of enrolled members who (1) turned 15 months old during the measurement year, (2) were continuously enrolled in the health plan from 31 days of age, and (3) received zero well-child visits with a primary care practitioner during their first 15 months of life.

It should be noted that limitations within the NCQA Data Submission Tool (DST), and differences in the way the health plans complete the DST, will impact any findings for data collection for this measure. Health plans may choose to attribute the finding of Zero Visits solely to administrative data sources, solely to medical record review, or to a combination of these. Any one of these approaches is acceptable; therefore, a comparison of data collection methods for this measure is not relevant and has not been included in this report.

Health Plan Ranking: Well-Child Visits in the First 15 Months of Life – Zero Visits

Figure 3-9—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life – Zero Visits



For this Key Measure, a *lower* rate indicates better performance, since low rates of Zero Visits indicate better care.

Figure 3-9 shows the percentage of children who received **no** well-child visits by age 15 months. For this measure, a *lower* rate indicates better performance.

Two health plans had reported rates that exceeded the HPL, while four health plans had rates below the LPL. A total of 10 health plans reported rates lower than the national HEDIS 2002 Medicaid 50th percentile, indicating better performance. The 18 reported rates ranged from 0.8 percent to 14.4 percent. Denominator sizes ranged from 43 to 432.

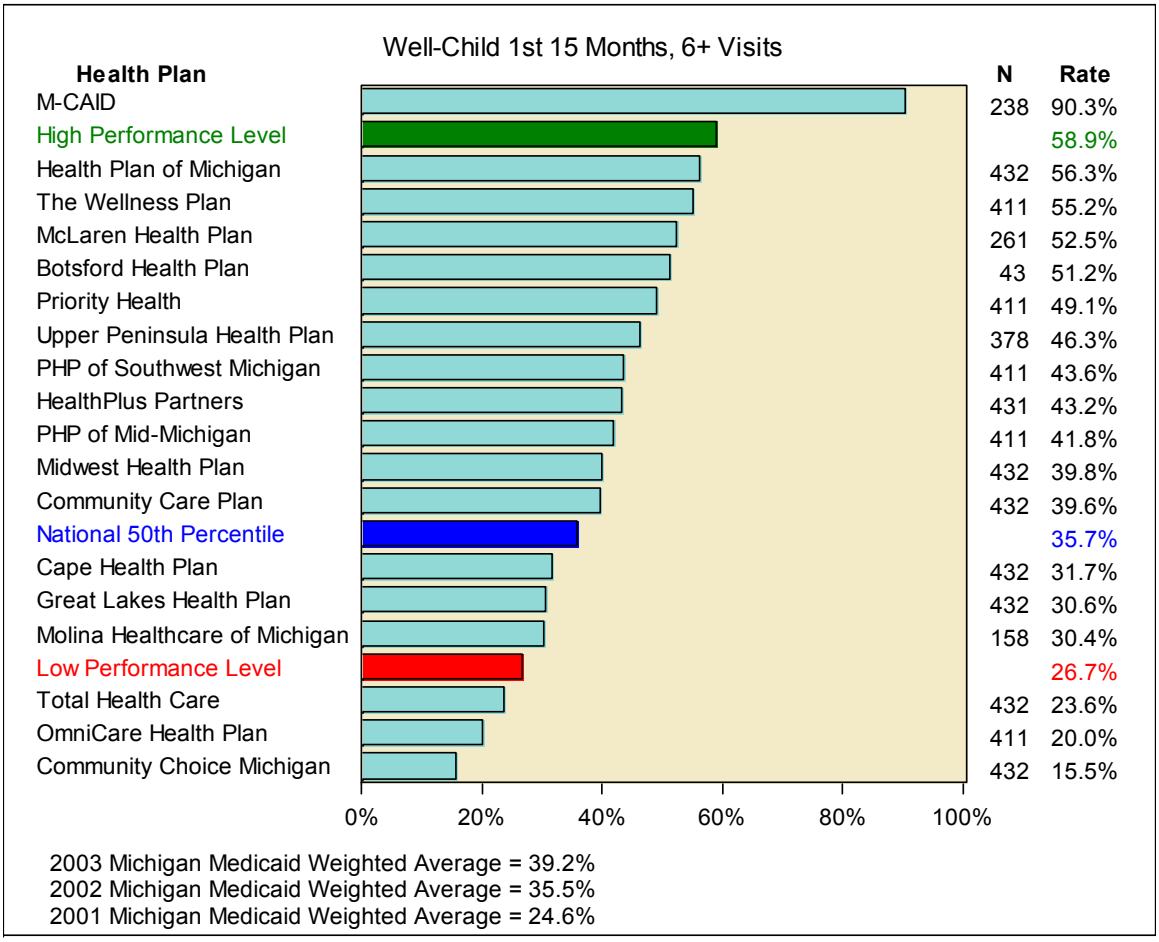
The 2003 Michigan Medicaid weighted average for the measure *Well-Child Visits in the First 15 Months of Life – Zero Visits* showed improvement, though not statistically significant when compared to the 2002 Michigan Medicaid weighted average. The Michigan Medicaid weighted average for *Zero Visits* moved from 6.5 percent in 2002 to 5.0 percent in 2003, while not yet reaching the national HEDIS 2002 Medicaid 50th percentile of 4.5 percent.

HEDIS Specification: Well-Child Visits in the First 15 Months of Life – Six or More Visits

The measure *Well-Child Visits in the First 15 Months of Life – Six or More Visits* calculates the percentage of enrolled members who (a) turned 15 months old during the measurement year, (b) were continuously enrolled in the health plan from 31 days of age, and (c) received six or more visits with a primary care practitioner during their first 15 months of life.

Health Plan Ranking: Well-Child Visits in the First 15 Months of Life – Six or More Visits

Figure 3-10—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life – Six or More Visits

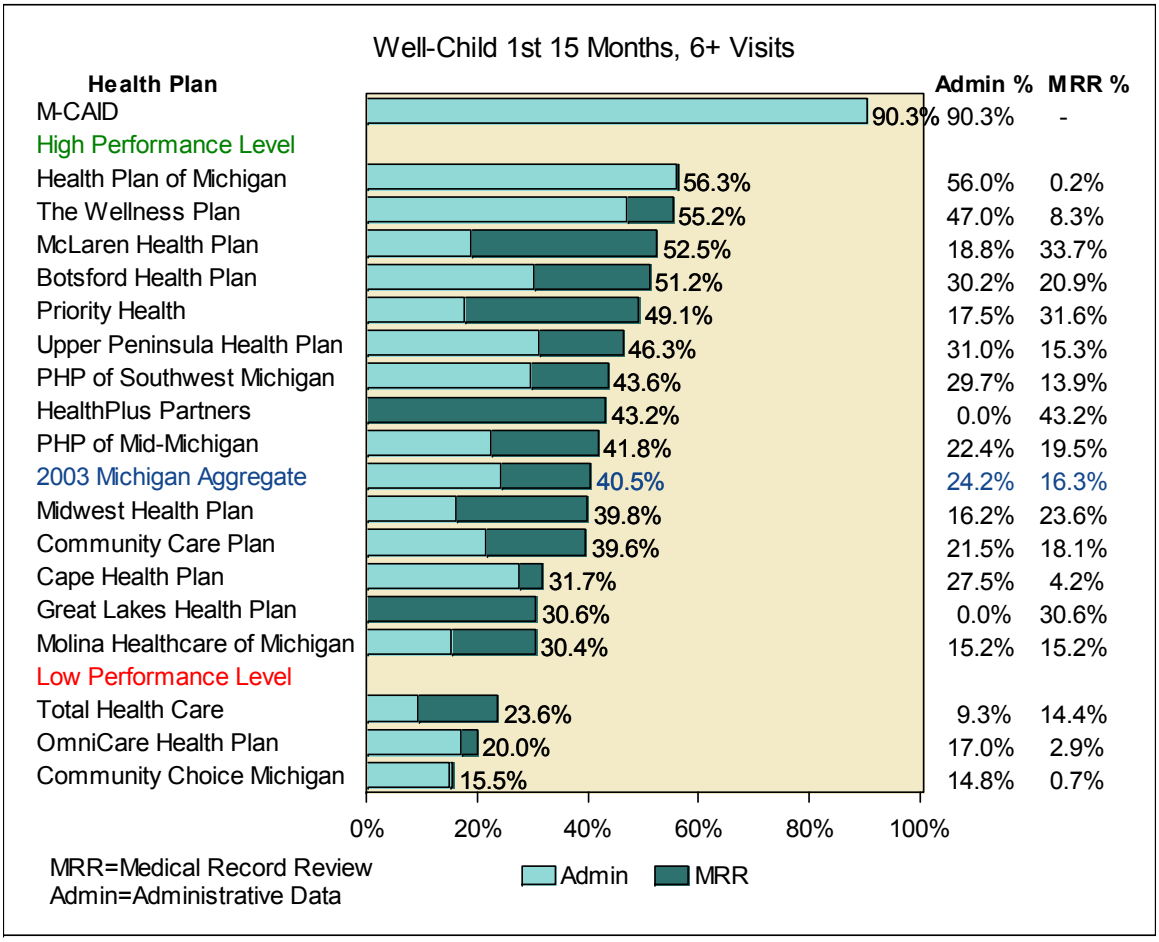


One health plan (M-CAID) had a reported rate that exceeded the HPL, while three health plans had rates below the LPL. A total of 12 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile. The 18 reported rates ranged from 15.5 percent to 90.3 percent. Denominator sizes ranged from 43 to 432.

The 2003 Michigan Medicaid weighted average of 39.2 percent was higher than both the national HEDIS 2002 Medicaid 50th percentile of 35.7 percent and the 2002 Michigan Medicaid weighted average of 35.5 percent. The 2003 Michigan Medicaid weighted average gain was not statistically significant, and represented a 3.7 percentage point increase over the previous year.

Data Collection Analysis: Well-Child Visits in the First 15 Months of Life – Six or More Visits

Figure 3-11—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Well-Child Visits in the First 15 Months of Life – Six or More Visits



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Overall, 17 of the 18 Michigan Medicaid health plans reported this measure using the hybrid method, while one used the administrative method. The 2003 Michigan aggregate administrative rate was 24.2 percent and the medical record review rate was 16.3 percent.

This result demonstrates that, overall, 59.8 percent of the aggregate rate was derived from administrative data and 40.2 percent from medical record review. Last year, 67.1 percent of the aggregate rate was derived from administrative data.

Twelve health plans derived more than half of their rate from administrative data, while two health plans had no administrative hits, with all of the final rate derived from medical record review.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

The AAP recommends annual well-child visits for two- to six-year-olds. These check-up visits during the preschool and early school years allow clinicians to detect vision, speech and language problems at the earliest opportunity. Early intervention in these areas can improve the child's communication skills and reduce language and learning problems.

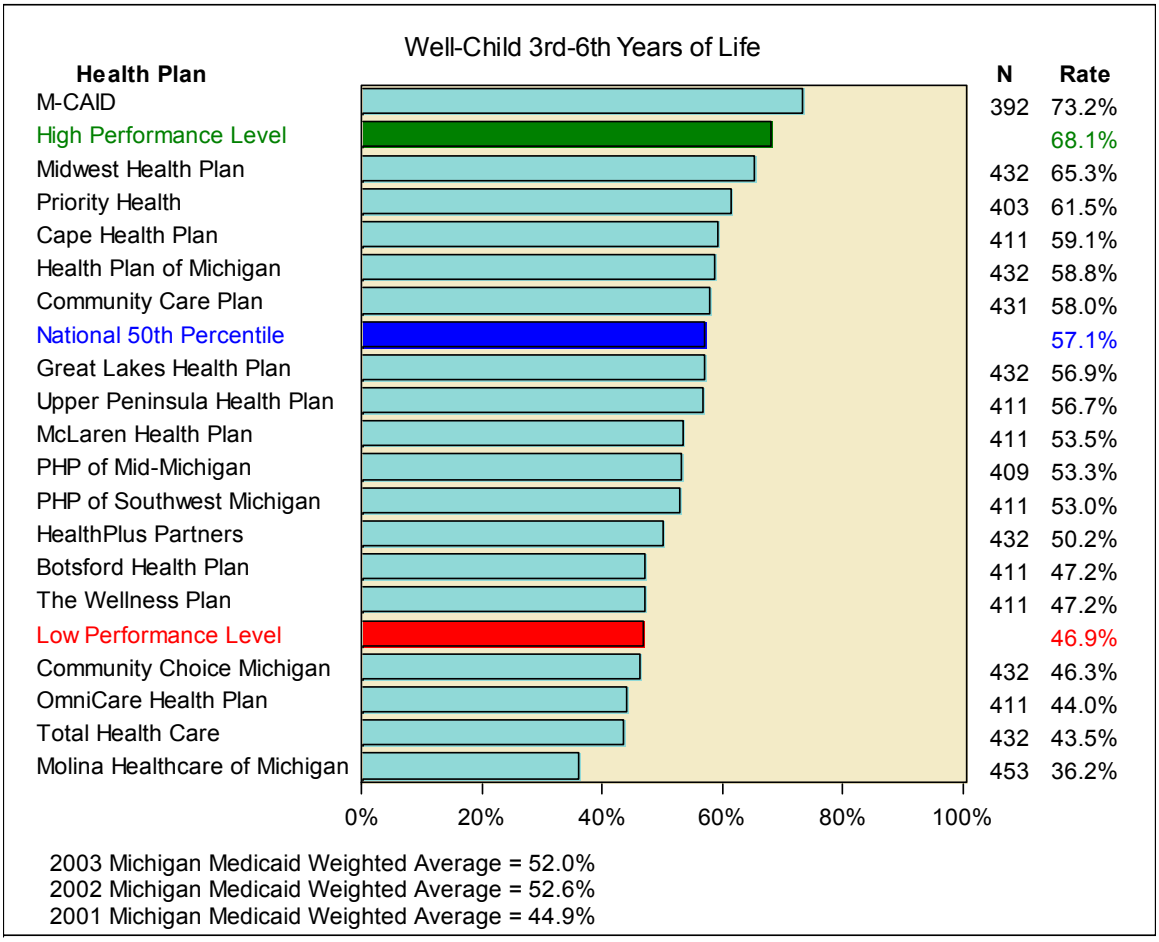
The following pages analyze in detail the performance profile, health plan rankings, and data collection methodology used by the Michigan Medicaid health plans for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*.

HEDIS Specification: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

This Key Measure, *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life,* reports the percentage of members who (a) were three, four, five, or six years old during the measurement year, (b) were continuously enrolled during the measurement year, and (c) received one or more well-child visits with a primary care practitioner during the measurement year.

Health Plan Ranking: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Figure 3-12—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

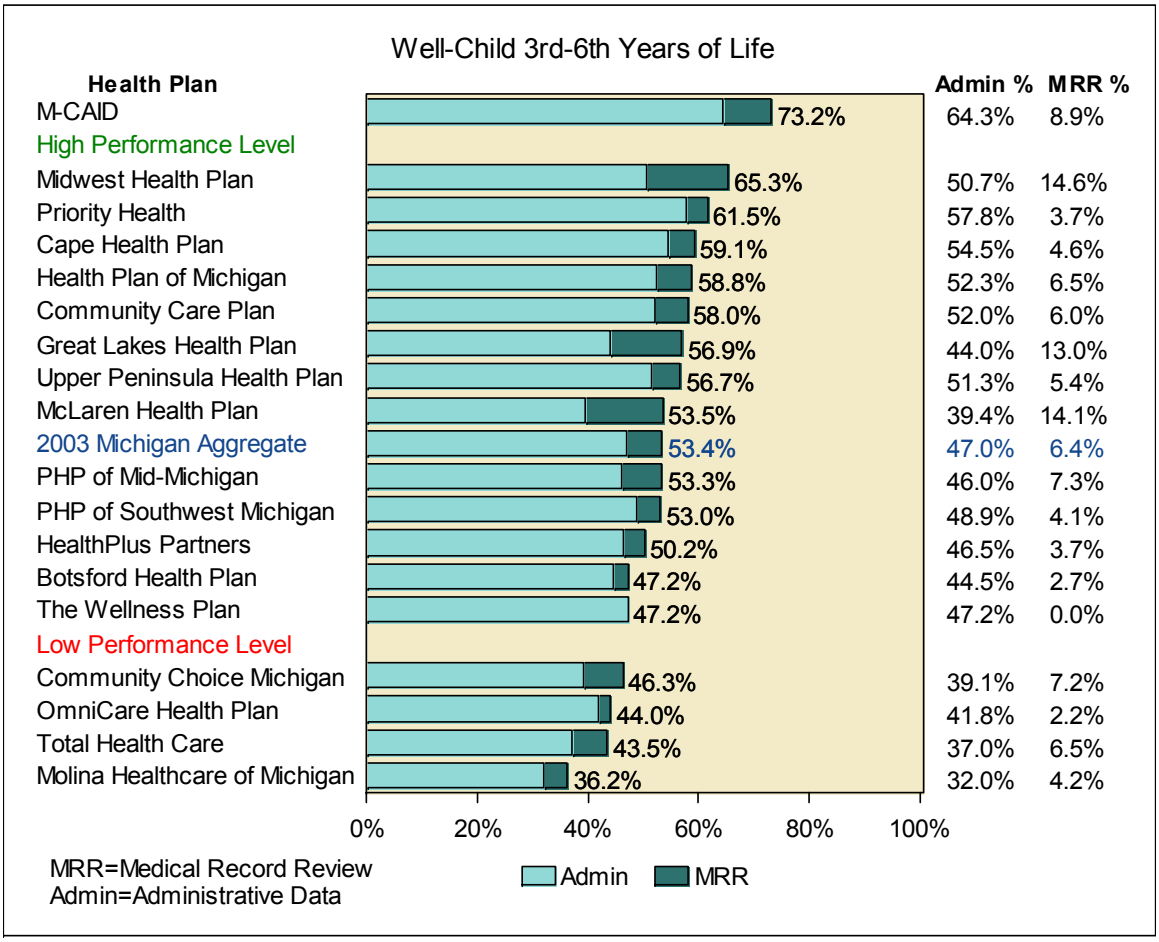


One health plan (M-CAID) had a reported rate that exceeded the HPL, while four health plans had rates below the LPL. A total of six health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile. The 18 reported rates ranged from 36.2 percent to 73.2 percent. Denominator sizes ranged from 392 to 453.

The 2003 Michigan Medicaid weighted average of 52.0 percent was lower than the national HEDIS 2002 Medicaid 50th percentile of 57.1 percent and slightly below the 2002 Michigan Medicaid weighted average of 52.6 percent. The 2003 Michigan Medicaid weighted average showed a 0.6 percentage point decrease from 2002; however, it was not statistically significant.

Data Collection Analysis: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Figure 3-13—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All 18 health plans reported the rate for W*ell-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* using the hybrid methodology. The 2003 Michigan aggregate administrative rate for this measure was 47.0 percent. All the health plans derived more than 70 percent of their rate from administrative data.

This result demonstrates that, overall, 88.0 percent of the aggregate rate was derived from administrative data and 12.0 percent from medical record review. Last year, 82.4 percent of the aggregate rate was derived from administrative data.

Overall, the 2003 Michigan aggregate rate increased by 6.4 percentage points using medical record review. Three health plans each had substantial improvements of more than 10 percentage points in their rate by using medical record review. One health plan (The Wellness Plan) reported the measure using the hybrid method but had no additional hits gained from medical record review. There is not sufficient information to determine if this was an error in reporting, incomplete medical record pursuit, or the health plan administrative data were relatively complete for this measure.

Adolescent Well-Care Visits

Adolescence is a period of profound change. More changes take place in anatomy, physiology, mental and emotional functioning, and social development during adolescence than in any other life stage, except infancy. Unintentional injuries, homicide, and suicide are the leading causes of adolescent death. Sexually transmitted diseases, substance abuse, pregnancy, and anti-social behavior are important causes of physical, emotional, and social problems among adolescents. The attitudes and behaviors molded during adolescence often determine the lifestyle and health habits of adulthood, creating long-term health implications.

The AMA Guidelines for Adolescent Preventive Services (GAPS), the federal government's Bright Futures programs, and the AAP guidelines all recommend comprehensive annual health care visits for adolescents. These annual check-ups provide opportunities for addressing the physical, emotional, and social aspects of their health.

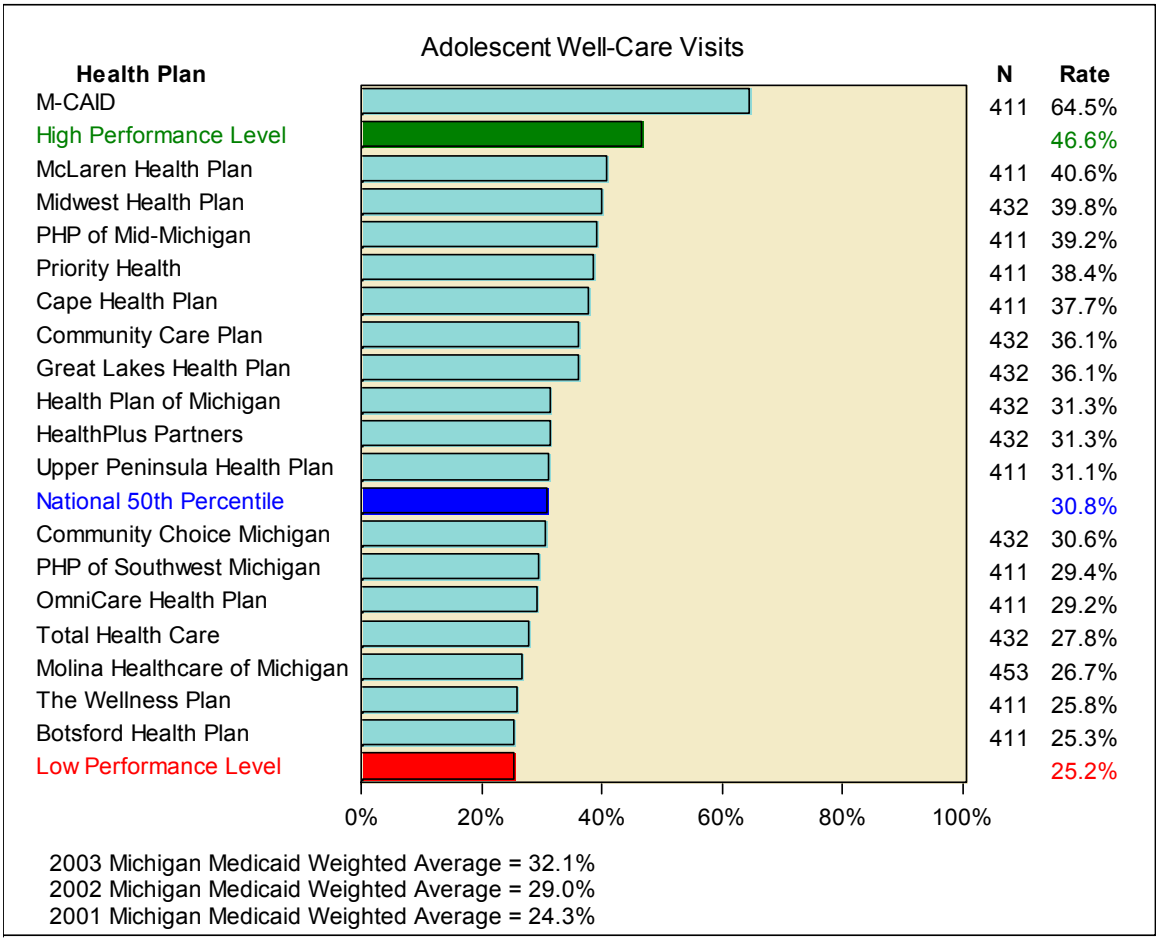
The following pages analyze in detail the performance profile, health plan rankings, and data collection methodology used by the Michigan Medicaid health plans for *Adolescent Well-Care Visits*.

HEDIS Specification: Adolescent Well-Care Visits

This Key Measure reports the percentage of enrolled members who (a) were aged 12 through 21 years during the measurement year, (b) were continuously enrolled during the measurement year, and (c) had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Health Plan Ranking: Adolescent Well-Care Visits

Figure 3-14—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Adolescent Well-Care Visits

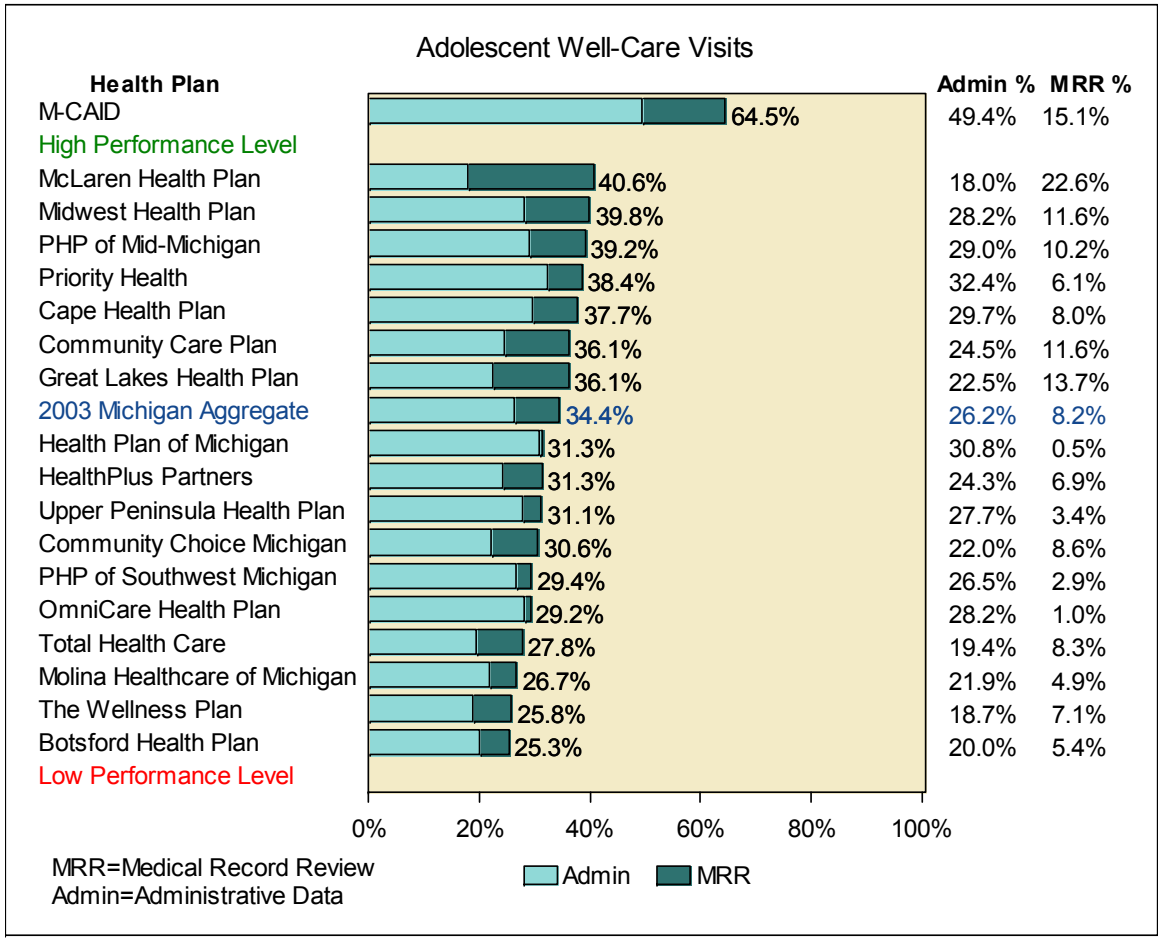


One health plan (M-CAID) had a reported rate that exceeded the HPL, while none of the health plans had rates below the LPL. A total of 11 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 32.1 percent was higher than both the national HEDIS 2002 Medicaid 50th percentile rate of 30.8 percent and the 2002 Michigan Medicaid weighted average of 29.0 percent. The Michigan Medicaid weighted average gain in 2003, of 3.1 percentage points, was not statistically significant. The 18 reported rates ranged from 25.3 percent to 64.5 percent. Denominator sizes ranged from 411 to 453.

Data Collection Analysis: Adolescent Well-Care Visits

Figure 3-15—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Adolescent Well-Care Visits



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

The 2003 Michigan aggregate administrative rate for this measure is 26.2 percent. Seventeen health plans with reported rates each derived at least half of their rate from administrative data. No health plan relied exclusively on administrative data this year, whereas five health plans relied exclusively on administrative data last year.

This result demonstrates that, overall, 76.2 percent of the aggregate rate was derived from administrative data and 23.8 percent from medical record review. Last year, 71.1 percent of the aggregate rate was derived from administrative data.

Overall, the 2003 Michigan aggregate rate increased by 8.2 percentage points by using medical record review. Six health plans had substantial improvements of 10 percentage points or more in their rate by using medical record review.

Pediatric Care Findings and Recommendations

The key findings indicate that:

- All of the Michigan Medicaid weighted averages are between the 50th and 75th percentiles, with the exception of *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, which was between the 25th and 50th percentiles.
- Michigan Medicaid health plans demonstrated notable improvement for seven of the eight Pediatric Care measures when compared to 2002. Overall, the rates for every measure reported in the Pediatric Care dimension have shown improvement since 2001.
- For *Childhood Immunization Status* and *Adolescent Immunization Status*, administrative data reporting is improving, but the administrative data are still under-reported. The majority of the immunization data for these measures require medical record review.

The 2003 Michigan Medicaid weighted average was 4.0 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile rate for *Childhood Immunization Status – Combination #1*. This measure has improved 8.1 percentage points since 2001. Overall, 65.4 percent of the rate for this measure was derived from administrative data.

For *Childhood Immunization Status – Combination #2*, the 2003 Michigan Medicaid weighted average was 6.6 percentage points above the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 14.8 percentage points since 2001. Overall, 64.8 percent of the rate for this measure was derived solely from administrative data, representing a 10.7 percentage point increase in the rate derived from administrative data.

The 2003 Michigan Medicaid weighted average was 4.9 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile rate for *Adolescent Immunization Status – Combination #1*. This measure has improved 13.8 percentage points since 2001. Overall, 46.4 percent of the rate for this measure was derived from administrative data.

For *Adolescent Immunization Status – Combination #2*, the 2003 Michigan Medicaid weighted average was 7.7 percentage points above the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 11.9 percentage points since 2001. Overall, 30.8 percent of the rate for this measure was derived from administrative data.

For *Well-Child Visits in the First 15 Months of Life – Zero Visits*, the 2003 Michigan Medicaid weighted average was nearly the same as the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 6.1 percentage points since 2001.

The 2003 Michigan Medicaid weighted average for *Well-Child Visits in the First 15 Months of Life – Six or More Visits* was 3.5 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 14.6 percentage points since 2001. Overall, 59.8 percent of the rate for this measure was derived from administrative data.

For *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, the 2003 Michigan Medicaid weighted average was 5.1 percentage points below the national HEDIS 2002 Medicaid 50th percentile. Although the overall 2003 rate for this measure was nearly identical to 2002, the rate has improved 7.1 percentage points since 2001. Overall, 88.0 percent of the rate for this measure was derived from administrative data. This indicates that administrative data for this measure is largely complete, although medical record review is still necessary for some health plans.

The 2003 Michigan Medicaid weighted average was 1.3 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile rate for *Adolescent Well-Care Visits*. This measure has improved 7.8 percentage points since 2001. Overall, 76.2 percent of the rate for this measure was derived from administrative data.

MDCH and the health plans can remind providers of the possibility of missed opportunities, such as "sick visits," where components of a well-child visit can occur and immunizations can be provided. Medicaid health plans in other states have conducted analysis of missed opportunities (e.g., determined if a child had any visit and then checked to see if that child had a well-child visit) and reported the findings to their providers as part of their provider education program. Member education was achieved through the health plan newsletters and reminder postcards. Used in tandem, provider education and member education have been shown to be very successful to improve reported rates in other states.

Provider incentives to submit encounter data have also had some success in improving rates for these measures. However, the results have been mixed, as the incentive for some providers may still not be sufficient to change behavior.

We recommend health plans perform an analysis of missed opportunities, and follow up with provider and member education. Proactively tracking well-child visits throughout the year and using reminder postcards may also be helpful in improving these rates.

Introduction

Michigan Medicaid provides care to over 264,000 women 20 through 64 years of age.[4-1] This section of the report addresses how well Michigan Medicaid health plans are doing at ensuring these women are screened early for cancer and sexually transmitted diseases (STDs), which are treatable if detected in the early stages. It also addresses how well Michigan Medicaid health plans are monitoring the appropriateness of prenatal and postpartum care.

The Women's Care dimension encompasses the following MDCH Key Measures:

- **Breast and Cervical Cancer Screening**
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
- **Chlamydia Screening**
  - *Chlamydia Screening in Women – Ages 16 to 20 Years*
  - *Chlamydia Screening in Women – Ages 21 to 26 Years*
  - *Chlamydia Screening in Women – Combined Rate*
- **Prenatal and Postpartum Care**
  - *Prenatal and Postpartum Care – Timeliness of Prenatal Care*
  - *Prenatal and Postpartum Care – Postpartum Care*

The following pages provide detailed analysis of Michigan Medicaid health plan performance and ranking, as well as data collection methodology used by Michigan Medicaid health plans for these measures.

[4-1] State of Michigan. Michigan Department of Community Health. Enrollment Services. Section Report BN-271. Run Date May 1, 2003.

Breast Cancer Screening

Breast cancer is one of the most common types of cancer among American women. In the United States, there will be an estimated 211,300 new cases of breast cancer and 40,200 deaths from breast cancer in 2003.[4-2] In 2003, the American Cancer Society estimates that 7,500 new cases of breast cancer will be diagnosed among women in Michigan.[4-3] While there has been a decline in the overall death rate in recent years, there is a significant racial disparity, with deaths among white women declining, but deaths among African-American, Hispanic, Asian, and Native American women not declining.[4-4]

If detected early, the five-year survival rate for localized breast cancer is 96 percent.[4-5] Mammograms can detect breast cancer an average of 1.7 years before the patient can feel a breast lump, and are the most effective method for detecting breast cancer in the early stages, when it is most treatable. In 2000, 8.8 percent of Michigan women aged 40 and older had never had a mammogram, down from 10.7 percent in 1999.[4-6] However, among Michigan women 40 years old and older, more than 41 percent do not receive appropriately timed breast cancer screening. Screening costs are low relative to the benefits of early detection. The average cost of treatment of early stage breast cancer is $11,000, rising to $140,000 for late stage treatment.[4-7]

HEDIS Specification: Breast Cancer Screening

The *Breast Cancer Screening* measure calculates the percentage of women who (a) were aged 50 through 69 years, (b) were continuously enrolled during the measurement year and the year prior to the measurement year, and (c) had a mammogram during the measurement year or the year prior to the measurement year.

[4-2] National Committee for Quality Assurance. *The State of Health Care Quality*. 2003 (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003:28.

[4-3] American Cancer Society Facts and Figures, 2003. Available at: http://www.cdc.gov/cancer/CancerBurden/mi.htm. Accessed on October 15, 2003.

[4-4] National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:35.

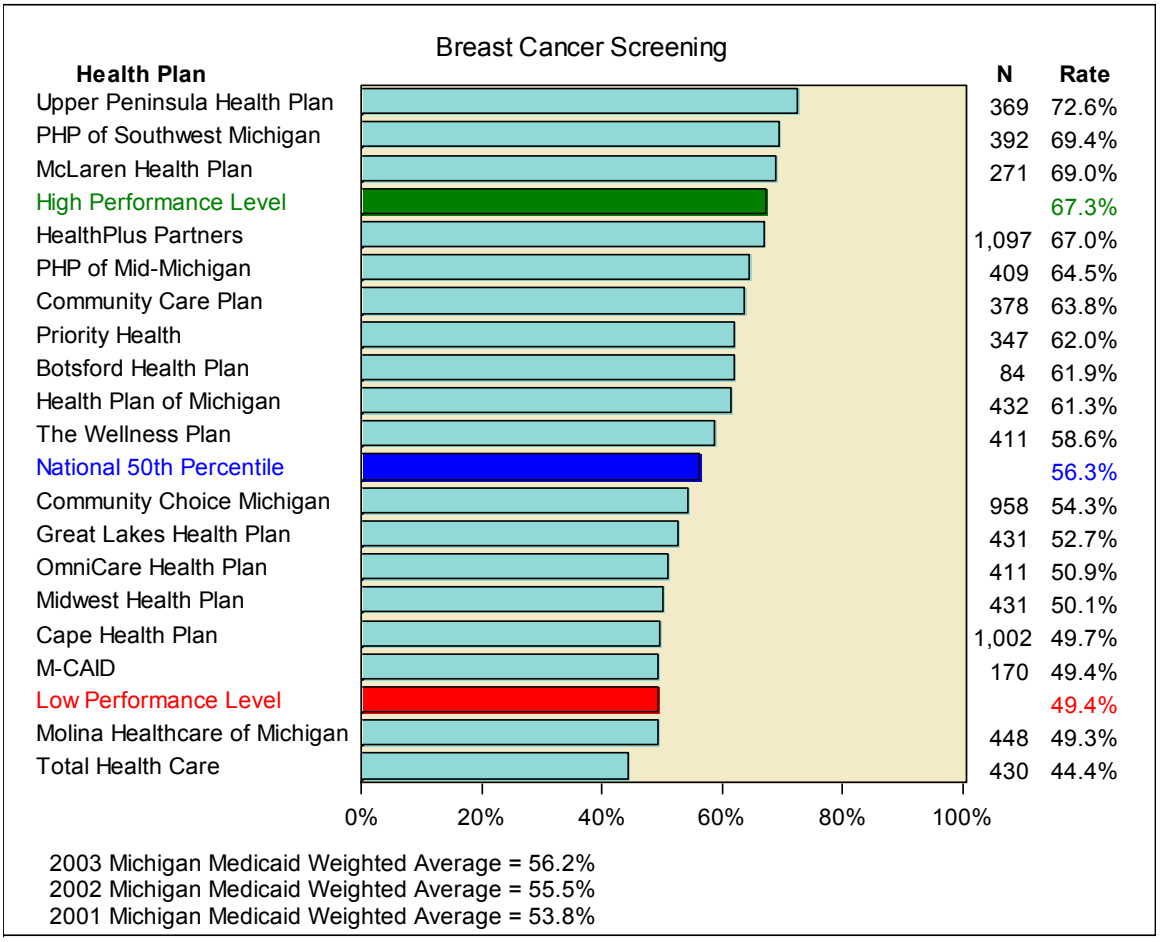
[4-5] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. The National Breast and Cervical Cancer Early Detection Program, 2003 Program Fact Sheet August 2003. Available at: http://www.cdc.gov/cancer/nbccedp/about.htm. Accessed on October 15, 2003.

[4-6] Michigan Department of Community Health, Facts about Breast Cancer September 2002. Available at: http://www.michigan.gov/documents/BreastFacts_6647_7.pdf. Accessed on October 15, 2003.

[4-7] National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:35.

Health Plan Ranking: Breast Cancer Screening

Figure 4-1—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Breast Cancer Screening



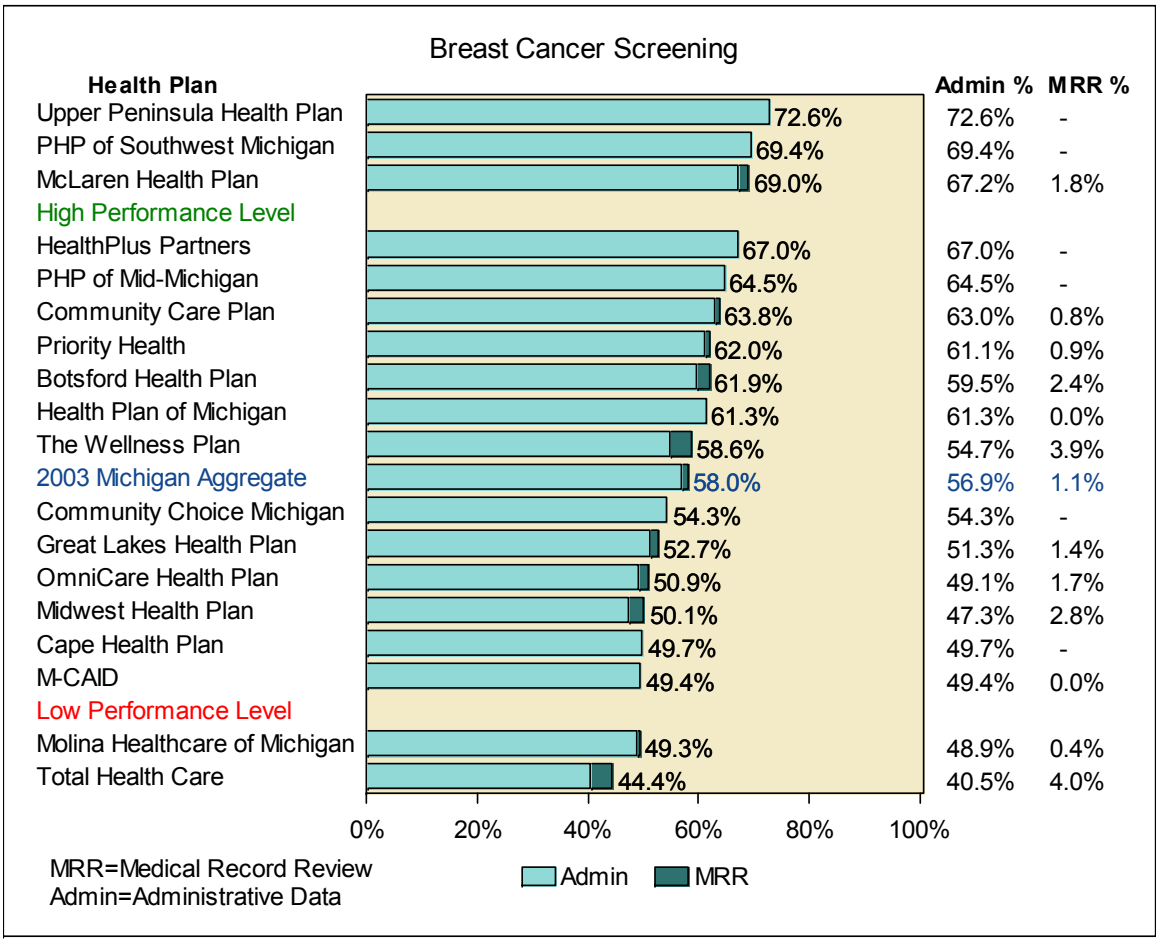
Three of the health plans had rates above the HPL of 67.3 percent, while two health plans had rates below the LPL of 49.4 percent. A total of 10 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 56.2 percent was just 0.1 of a percentage point below the national HEDIS 2002 Medicaid 50th percentile of 56.3 percent. The reported rates ranged from a low of 44.4 percent to a high of 72.6 percent.

The trend for the *Breast Cancer Screening* rate has not shown any significant change compared to 2001 and 2002, when the reported rates for the Michigan Medicaid weighted averages were 53.8 and 55.5 percent, respectively. However, more health plans have exceeded the HPL and fewer health plans have reported rates below the LPL than in prior years.

Data Collection Analysis: Breast Cancer Screening

Figure 4-2—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Breast Cancer Screening



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

The 2003 Michigan aggregate administrative rate for this measure was 56.9 percent. Six health plans elected to report this measure using the administrative methodology, while 12 health plans used the hybrid methodology. Four of the top five performing health plans reported this rate using the administrative method. Complete and accurate submission of claims/encounter data are essential for accurate reporting of this measure. Overall, 98.1 percent of the aggregate rate was derived from administrative data and 1.9 percent from medical record review. Last year, 96.8 percent of the aggregate rate was derived from administrative data.

The 2003 Michigan aggregate rate shows that the total rate increased by only 1.1 percentage points through the use of medical record review. This suggests that the health plans' administrative data are generally complete for this measure. M-CAID and Health Plan of Michigan experienced no increase in final rate despite the use of the hybrid methodology. This may be due to a difficulty at the health plan level in medical record retrieval or difficulty with identification of the most likely provider.

Cervical Cancer Screening

Cervical cancer is one of the most successfully treatable cancers when detected early. Unfortunately, in 2003, an estimated 12,200 new cases of cervical cancer, with 4,100 deaths from the disease, are expected in the United States. Almost 95 percent of Michigan women 18 and older have received at least one Pap smear during their lifetime. Eighty-six percent of Michigan women 18 and older have received a Pap smear within the past three years.[4-8] With screening, a woman's lifetime risk of cervical cancer is estimated to be only 0.8 percent.[4-9]

HEDIS Specification: Cervical Cancer Screening

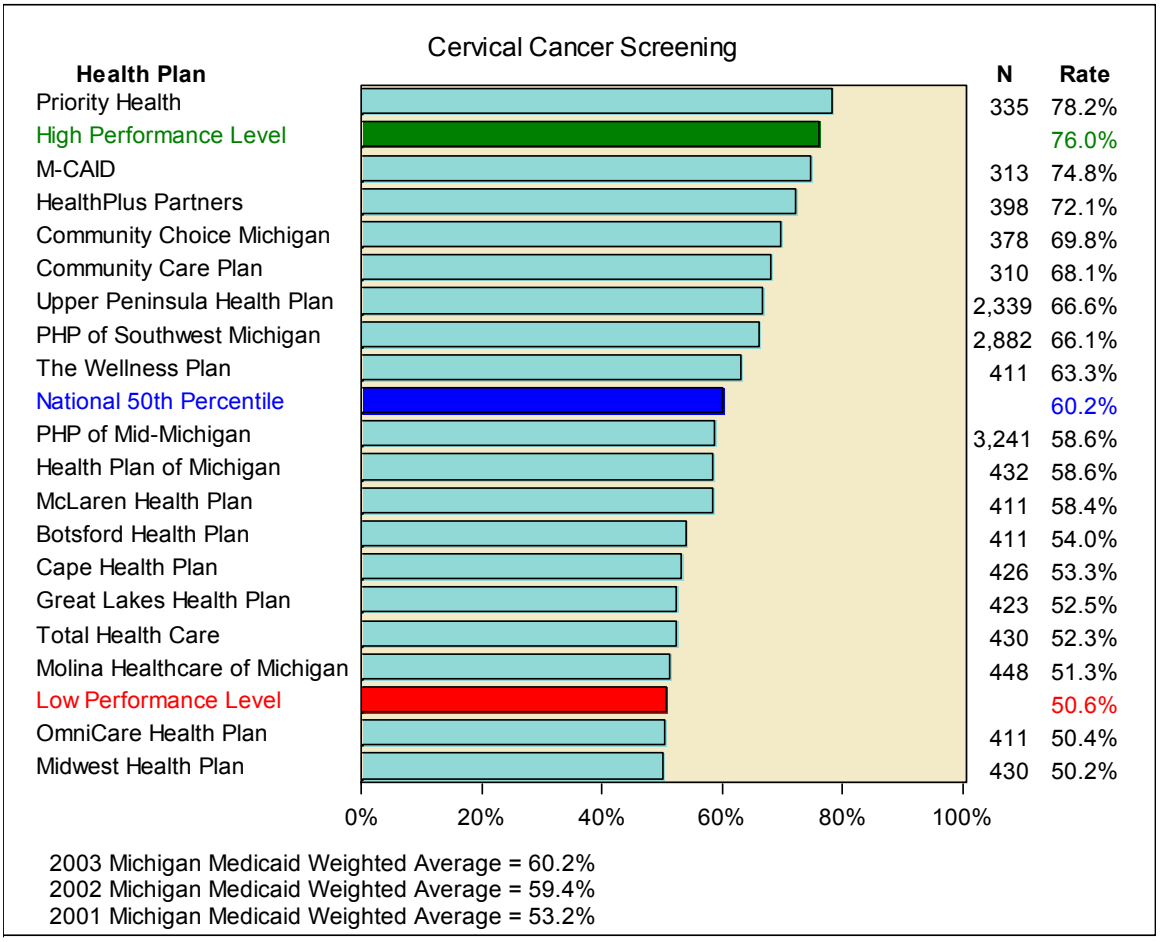
The *Cervical Cancer Screening* measure reports the percentage of women aged 18 through 64 years who were continuously enrolled during the measurement year and who received one or more Pap tests during the measurement year or the two years prior to the measurement year.

[4-8] Michigan Department of Community Health: Facts about Cervical Cancer September 2002 Available at: http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf. Accessed on October 15, 2003.

[4-9] National Committee for Quality Assurance. *The State of Health Care Quality. 2003* (Standard Version) Washington, DC: National Committee for Quality Assurance; 2003:29.

Health Plan Ranking: Cervical Cancer Screening

Figure 4-3—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Cervical Cancer Screening



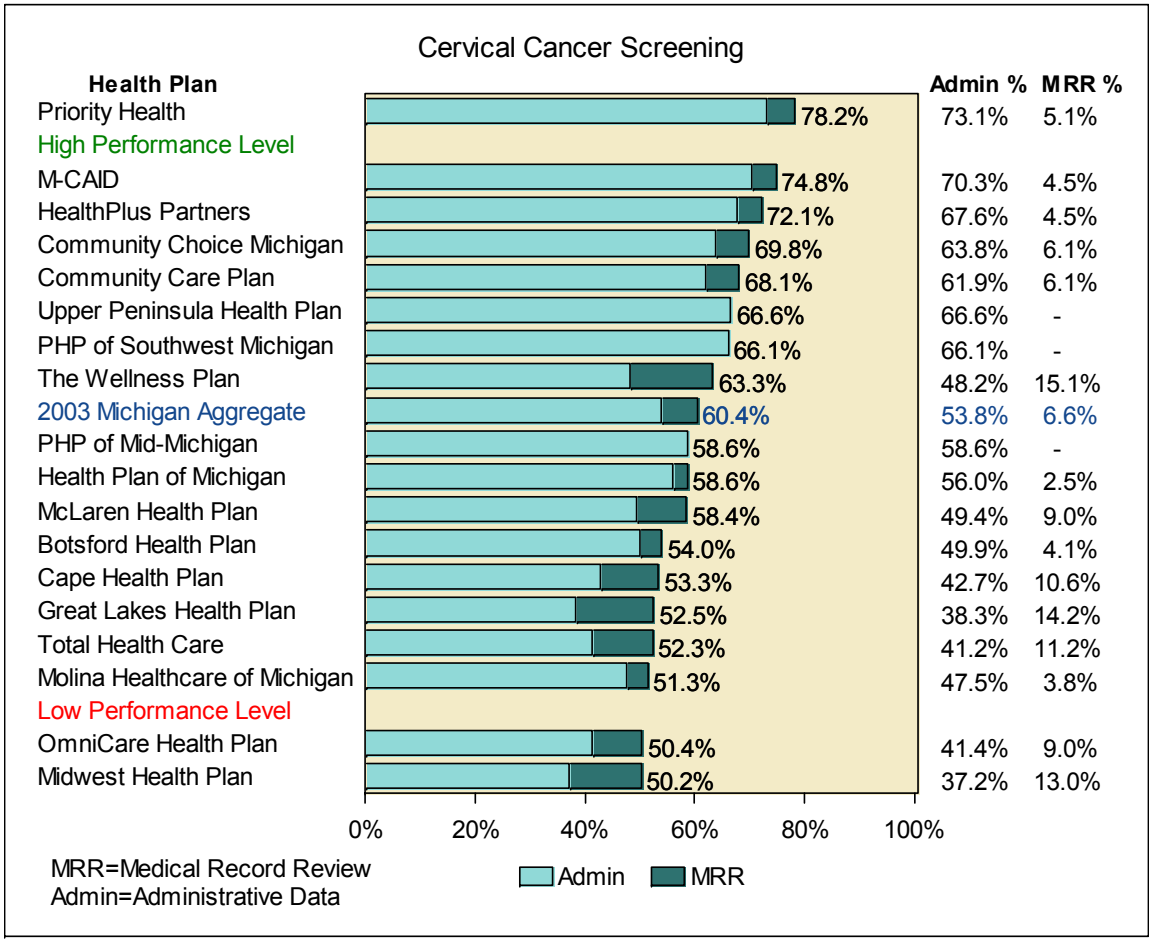
One health plan had a rate above the HPL of 76.0 percent, while two health plans had rates below the LPL of 50.6 percent. A total of eight health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 60.2 percent was identical to the national HEDIS 2002 Medicaid 50th percentile. The reported rates ranged from a low of 50.2 percent to a high of 78.2 percent.

The trend for the *Cervical Cancer Screening* rate did not improve significantly over 2002, and has shown a 7.0 percentage point increase since 2001. However, more health plans have exceeded the HPL and fewer health plans have reported rates below the LPL than in prior years. The two health plans below the LPL this year reported rates that were above last year's LPL.

Data Collection Analysis: Cervical Cancer Screening

Figure 4-4—Michigan Medicaid HEDIS 2003 Data Collection Analysis: *Cervical Cancer Screening*



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Three health plans used the administrative method, while fifteen health plans used the hybrid method. *Cervical Cancer Screening* benefits from a health plan's ability to access claims/encounter data. This measure relies extensively on vendor data, specifically lab data. The 2003 Michigan aggregate administrative rate was 53.8 percent.

Overall, 89.1 percent of the aggregate rate was derived from administrative data and 10.9 percent from medical record review. Last year, 81.3 percent of the aggregate rate was derived from administrative data.

The 2003 Michigan aggregate rate increased by 6.6 percentage points using medical record review. Because screenings may be more likely to take place at an OB/GYN office or women's care clinics rather than solely with a primary care provider, identifying the most likely provider for the eligible women is an important part of a successful medical record review.

Chlamydia Screening in Women

There are approximately 3 million new cases of chlamydia annually, making it the most common sexually transmitted disease (STD) in the United States.[4-10] Chlamydia can be successfully treated with antibiotics. Untreated chlamydia increases the risk for pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and HIV infection, yet women who are infected have no obvious symptoms. Nearly 80 percent of women infected are 24 years or younger. Of the approximately 40 percent of infected women who develop PID, 20 percent become infertile, 18 percent experience severe pelvic pain, and 9 percent have a life-threatening ectopic pregnancy.[4-11]

The *Chlamydia Screening in Women* measure is reported using the administrative method only.

HEDIS Specification: Chlamydia Screening in Women

The measure is reported by three separate rates: *Ages 16 to 20 Years*, *Ages 21 to 26 Years* and a *Combined Rate* of both age groups (for ages 16 to 26 years). For each age group, the measure calculates the percentage of women who were identified as sexually active, who were continuously enrolled during the measurement year and had at last one test for chlamydia during the measurement year.

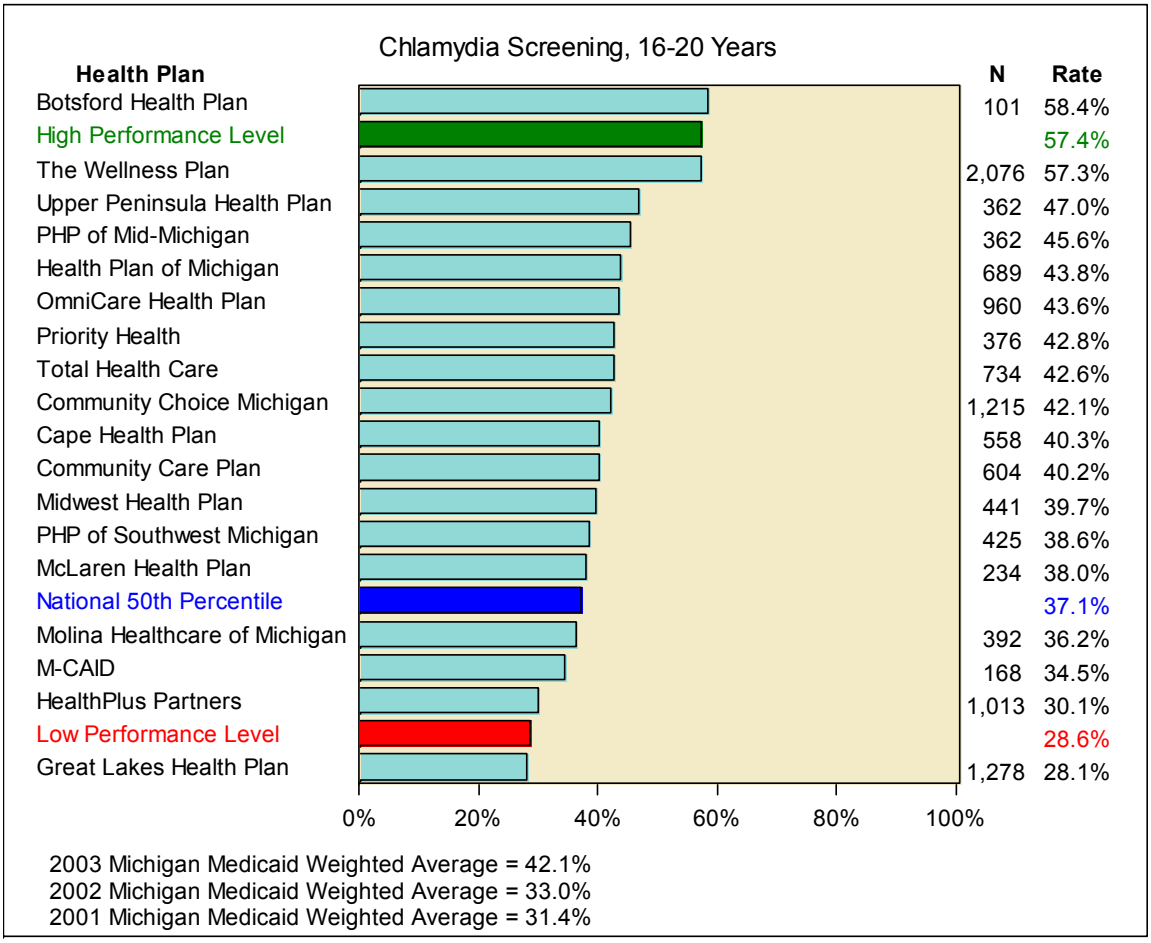
Chlamydia screening can only be reported using the administrative methodology. Since health plans may not use medical records to supplement any data completeness concerns, accurate and timely submission of claims/encounters from providers and vendors is essential to accurately reflect services and care rendered. In addition to the age requirement, women must be identified as sexually active to be eligible for this measure. Thus the denominator is also dependent on complete and accurate claims/encounter data, including external vendor pharmacy data. Since this measure is collected using administrative data only, identifying and integrating as many administrative data sources as possible is essential if rates are to accurately reflect services rendered.

[4-10] National Committee for Quality Assurance. *The State of Health Care Quality, 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003:31.

[4-11] University of Michigan Health System. Women need testing and care for infection that can steal fertility expert says [press release]. University of Michigan; March 26, 2001. Available at: http://www.med.umich.edu/opm/newspage/2001/chlam.html. Accessed on October 20, 2003.

Health Plan Ranking: Chlamydia Screening in Women – Ages 16 to 20 Years

Figure 4-5—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Chlamydia Screening in Women – Ages 16 to 20 Years



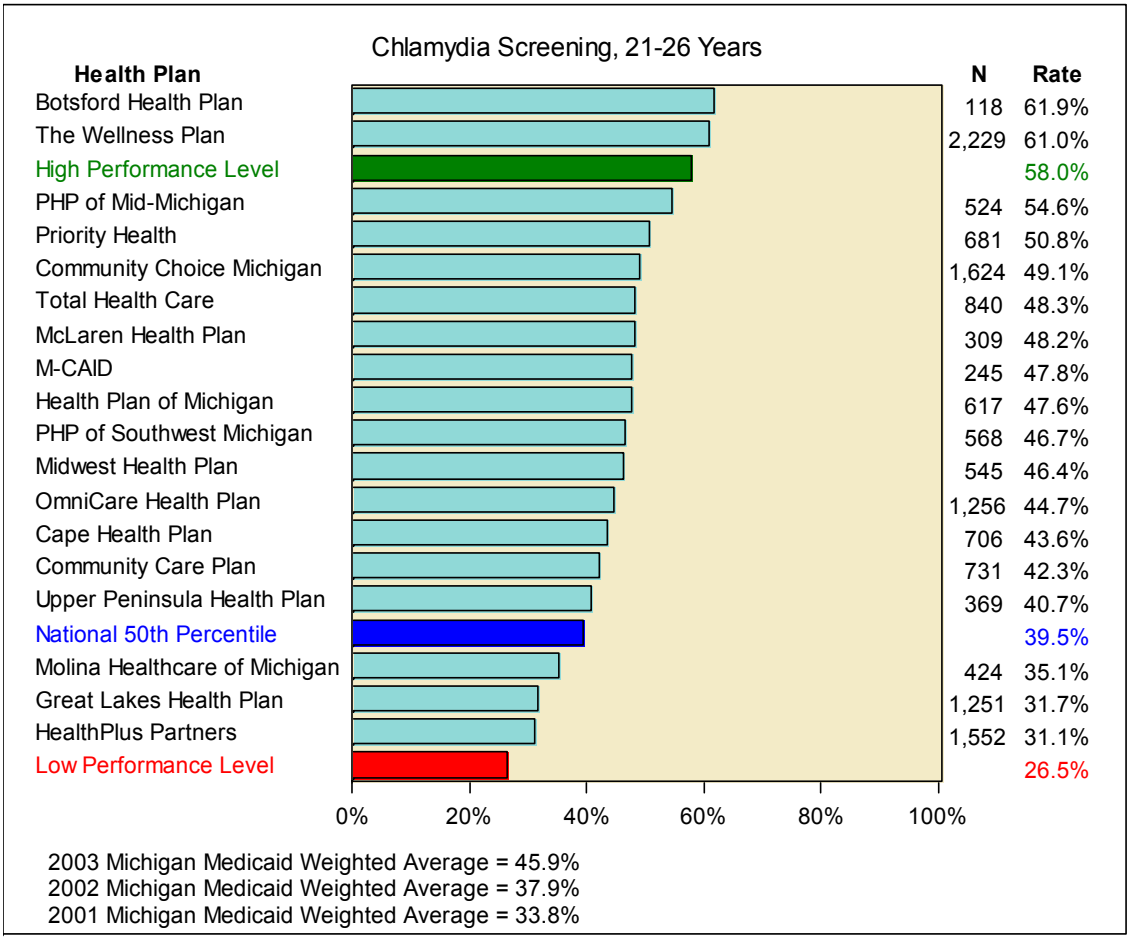
One health plan reported a rate above the HPL of 57.4 percent, and one health plan reported a rate below the LPL of 28.6 percent. At total of 14 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 42.1 percent was 5.0 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile. The reported rates ranged from a low of 28.1 percent to a high of 58.4 percent.

The trend for the rate for *Chlamydia Screening in Women – Ages 16 to 20 Years* has shown significant improvement since 2001, gaining 10.7 percentage points from 2001. Last year's rate improved by 9.1 percentage points. Compared with 2002, one health plan exceeded the HPL and fewer health plans reported rates below the LPL.

Health Plan Ranking: Chlamydia Screening in Women – Ages 21 to 26 Years

Figure 4-6—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Chlamydia Screening in Women – Ages 21 to 26 Years



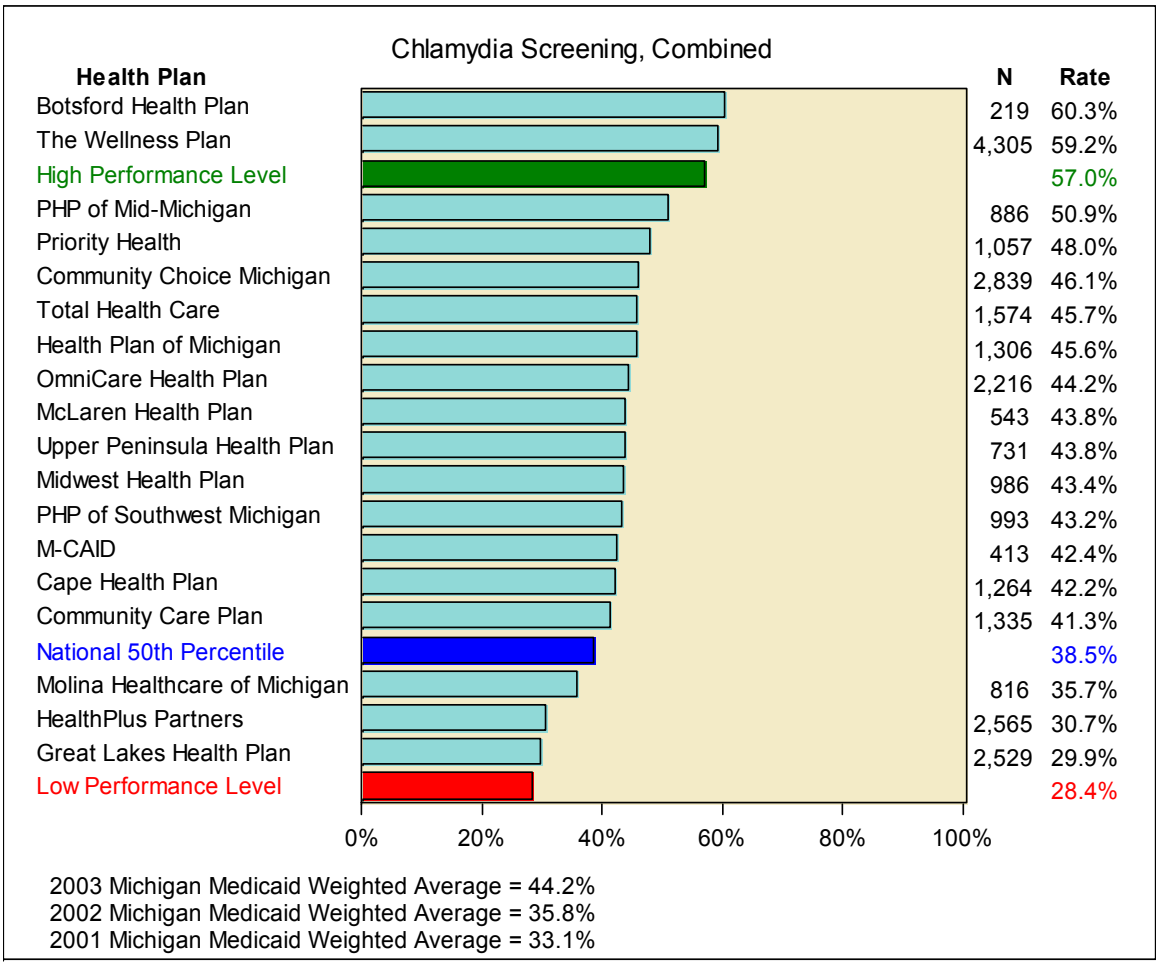
Two health plans reported a rate above the HPL of 58.0 percent, while none of the health plans reported a rate below the LPL. A total of 15 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 45.9 percent was 6.4 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile of 39.5 percent. The reported rates ranged from a low of 31.1 percent to a high of 61.9 percent.

The trend for the rate for *Chlamydia Screening in Women – Ages 21 to 26 Years* has shown significant improvement since 2001, gaining 12.1 percentage points from 2001. Last year's rate improved by 8.0 percentage points. None of the health plans exceeded the HPL in 2002, while two health plans exceeded this year's HPL. Similarly, two health plans reported rates below the LPL in 2002, compared to none that were below the LPL for 2003.

Health Plan Ranking: Chlamydia Screening in Women – Combined Rate

Figure 4-7—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Chlamydia Screening in Women – *Combined Rate*



Two health plans reported a rate above the HPL of 57.0 percent, while none of the health plans reported a rate below the LPL. A total of 15 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile of 38.5 percent.

The 2003 Michigan Medicaid weighted average of 44.2 percent was 5.7 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile of 38.5 percent. The reported rates ranged from a low of 29.9 percent to a high of 60.3 percent.

The trend for the rate for *Chlamydia Screening in Women – Combined* has shown significant improvement since 2001, gaining 11.1 percentage points from 2001. Last year's rate improved by 8.4 percentage points. Additionally, none of the health plans exceeded the HPL in 2002, while two health plans exceeded this year's HPL. Similarly, two health plans reported rates below the LPL in 2002, yet none were below the LPL for 2003.

Prenatal and Postpartum Care

In the United States, more than 250,000 low-birth weight infants are born each year.[4-12] Approximately 205 low-birth weight infants are born in an average week in Michigan.[4-13] In 2001, 8 percent of Michigan infants were born with low birth weight.[4-14] Several studies show a positive relationship between comprehensive prenatal care and reduction in low birth weight and infant mortality. HEDIS measures two important components of care: timeliness of prenatal care and health care for the mother up to 56 days after delivery. Adequate prenatal care, including initiating care in the first trimester and receiving regular care until delivery, can result in fewer birth complications and healthier babies.[4-15]

Michigan ranks 41st nationally in infant mortality, and the disparity among rates for different racial groups is increasing.[4-16] In 2001, the infant mortality rate for African-Americans was 16.9 per 1,000 live births, while for whites it was 6.1 per 1,000 live births.[4-17] African-American women in Michigan also have a higher rate of maternal mortality than white women, the largest racial gap in the nation. Michigan women under the age of 20 are least likely to receive adequate levels of prenatal care, and African-American women are two to three times more likely to experience inadequate levels of care when compared to women of other races.

This Key Measure examines whether or not care is available to members when needed and whether that care is provided in a timely manner. The measure consists of two numerators: Timeliness of Prenatal Care and Postpartum Care, giving rise to the MDCH Key Measure names:

- Prenatal and Postpartum Care – Timeliness of Prenatal Care
- Prenatal and Postpartum Care – Postpartum Care

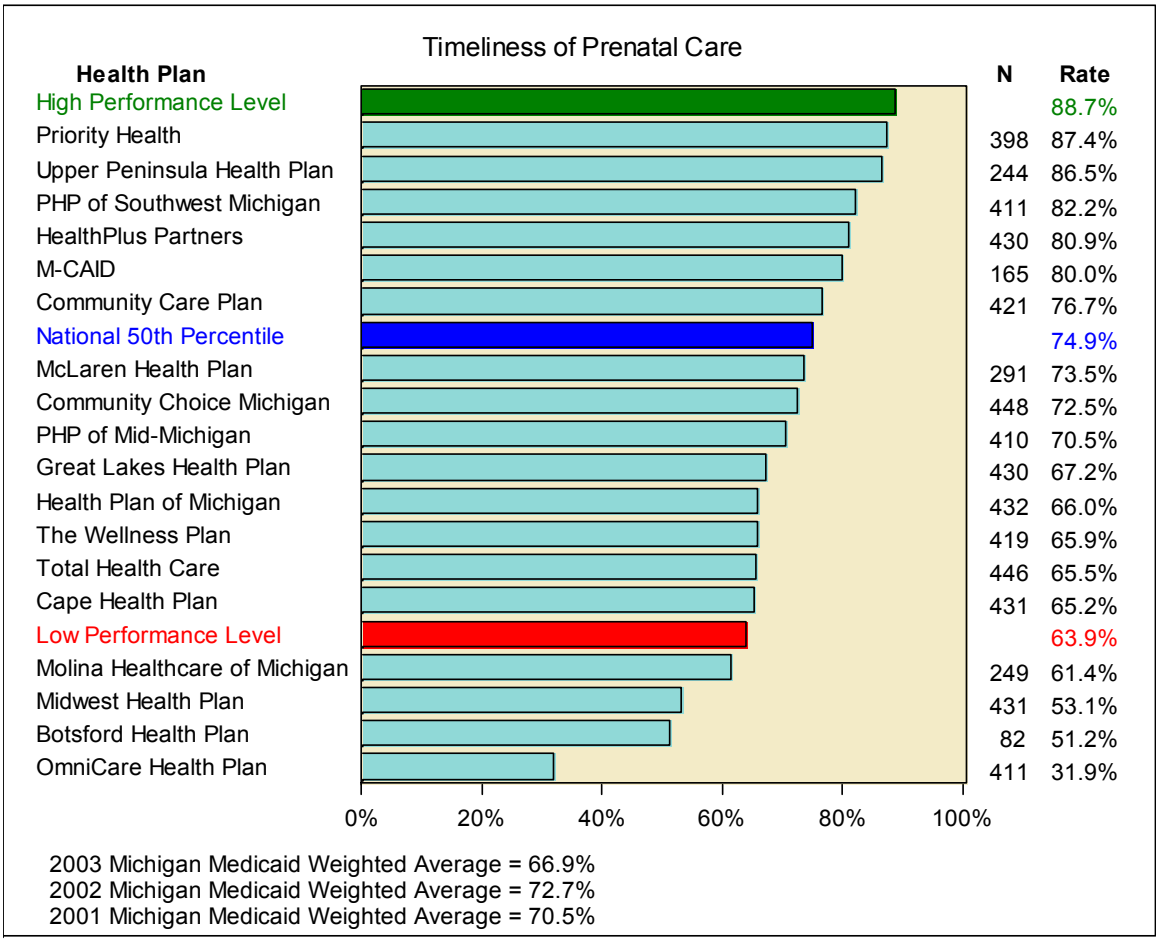
HEDIS Specification: Prenatal and Postpartum Care – Timeliness of Prenatal Care

The *Prenatal and Postpartum Care – Timeliness of Prenatal Care* measure calculates the percentage of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery, and who received a prenatal care visit as a member of the health plan in the first trimester or within 42 days of enrollment in the health plan.

[4-12] National Committee for Quality Assurance. *The State of Health Care Quality 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003:37.
[4-13] Michigan March of Dimes Birth Defects Foundation. Available at: http://peristats.modimes.org/prematurity.cfm?state_id=26&level=state. Accessed on October 15, 2003.
[4-14] Michigan March of Dimes Birth Defects Foundation. *Perinatal Profiles: Statistics for Monitoring State Maternal and Infant Health*; 2002: 1.
[4-15] National Committee for Quality Assurance. *The State of Health Care Quality 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003:37.
[4-16] United Health Foundation. State Health Ranking. 2002 Edition. Available at: http://www.unitedhealthfoundation.org/shr2002/components/outcomes/InfantMortality.html. Accessed on October 21, 2003.
[4-17] Michigan Department of Community Health. Summary of 2001 Infant Death Statistics. Available at: http://www.mdch.state.mi.us/pha/osr/InDxMain/Infsum01.asp. Accessed on October 21, 2003.

Health Plan Ranking: Prenatal and Postpartum Care – Timeliness of Prenatal Care

Figure 4-8—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Prenatal and Postpartum Care – Timeliness of Prenatal Care



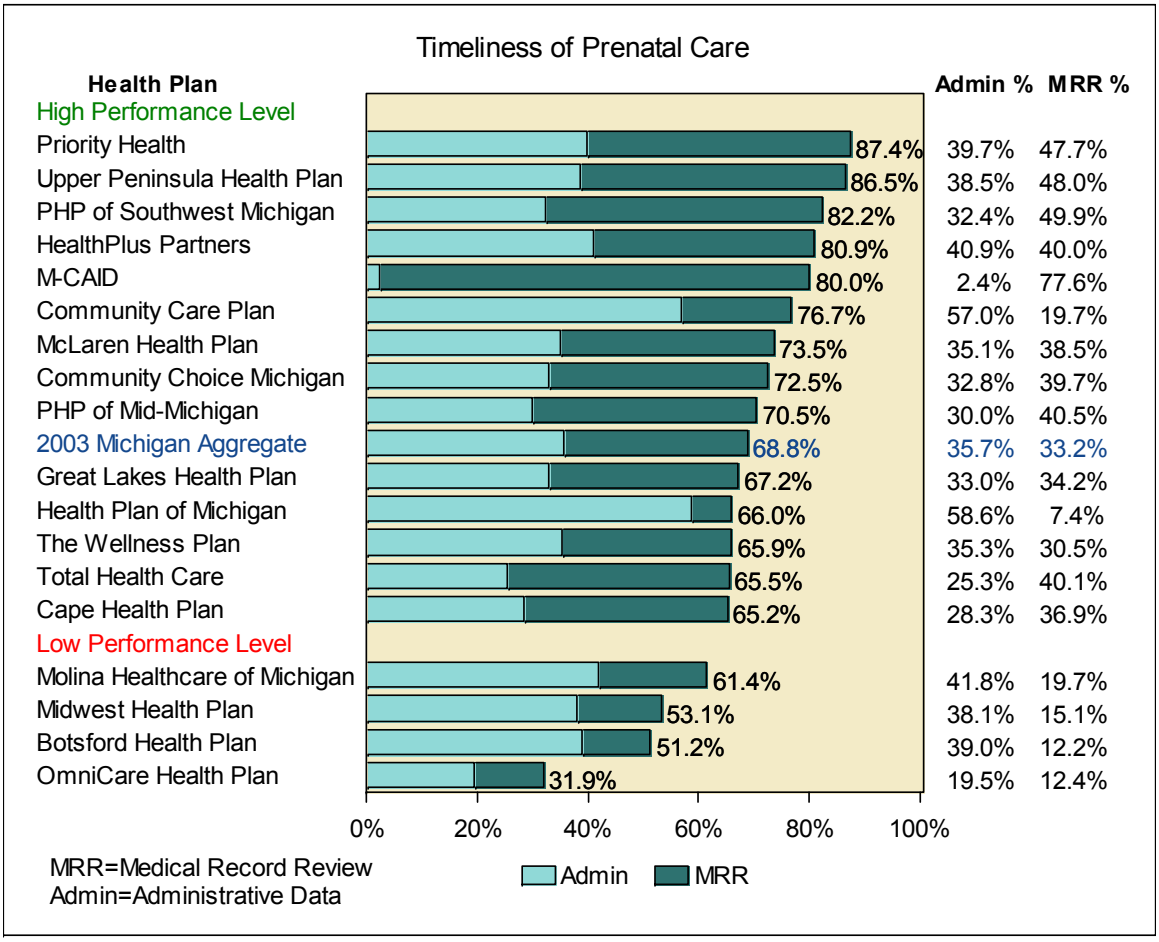
None of the health plans reported rates above the HPL of 88.7 percent, although six health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile. Four health plans reported rates below the LPL of 63.9 percent.

The 2003 Michigan Medicaid weighted average of 66.9 percent was 8.0 percentage points below the national HEDIS 2002 Medicaid 50th percentile of 74.9 percent. The reported rates ranged from a low of 31.9 percent to a high of 87.4 percent.

The *Timeliness of Prenatal Care* rate for the Michigan Medicaid weighted average declined 5.8 percentage points this year, as the rate changed from 72.7 percent in 2002 to 66.9 percent for 2003. Although there were fewer health plans below the LPL in 2003 than in 2002, none of the health plans exceeded the HPL in 2003 compared to three health plans that exceeded the HPL in 2002.

Data Collection Analysis: Prenatal and Postpartum Care – Timeliness of Prenatal Care

Figure 4-9—Michigan Medicaid HEDIS 2003 Data Collection Analysis: *Prenatal and Postpartum Care – Timeliness of Prenatal Care*



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All 18 health plans elected to report this measure using the hybrid method. The 2003 Michigan aggregate administrative rate was 35.7 percent. The administrative rate range continues to be substantial, ranging from 2.4 percent to 58.6 percent.

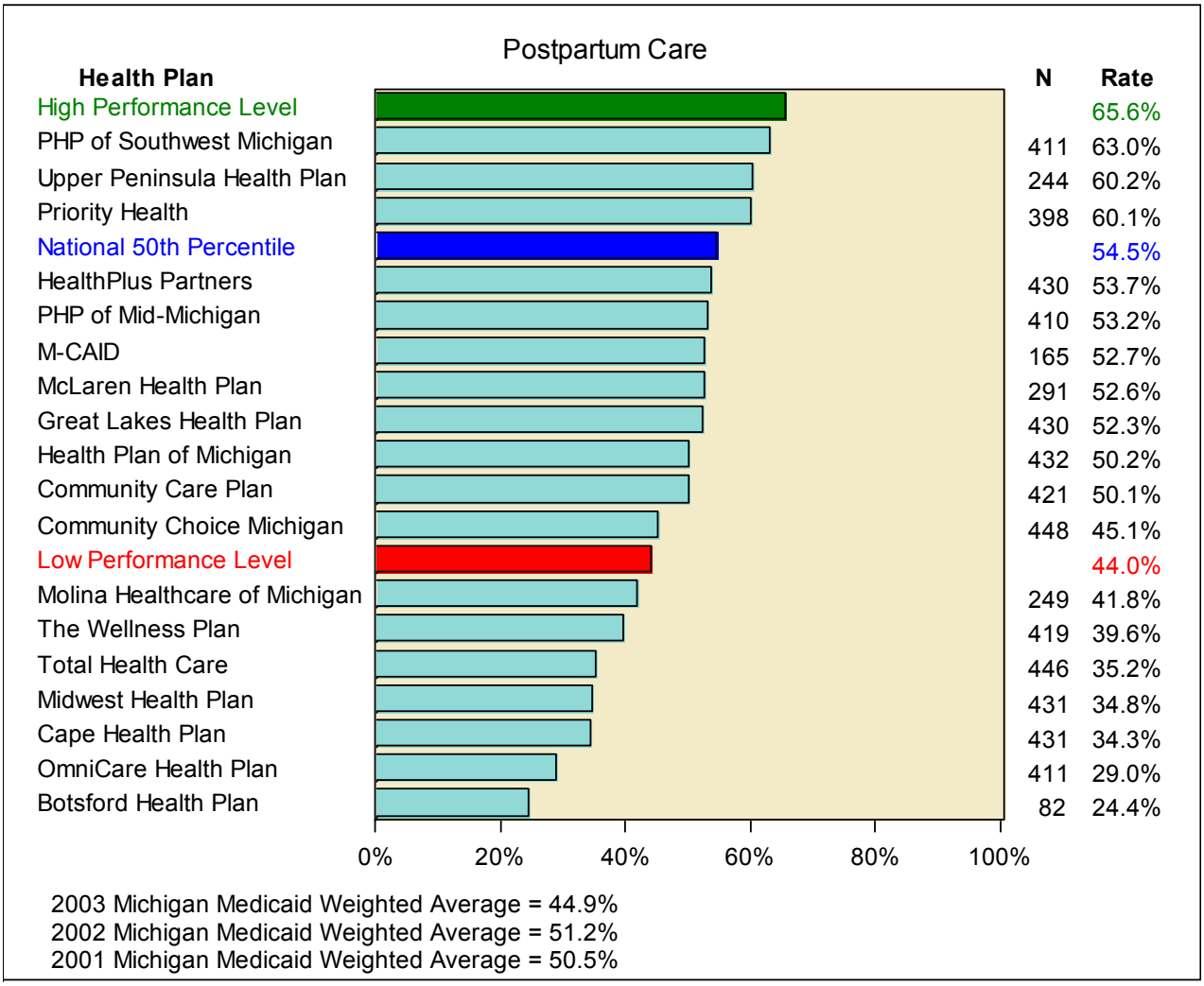
This result demonstrates that 51.9 percent of the aggregate rate was derived from administrative data and 48.1 percent from medical record review. Last year, 51.7 percent of the aggregate rate was derived from administrative data. Overall, the 2003 Michigan aggregate rate increased 33.2 percentage points from medical record review. Identifying numerator events via administrative data are made difficult by such issues as capitation of maternity-related services and global billing practices. Thus, medical record review is a benefit to this measure. It is challenging to find the correct provider in a prenatal setting, because the provider who delivers the infant may not have been the same provider who gave prenatal care to the mother.

HEDIS Specification: Prenatal and Postpartum Care – Postpartum Care

The *Prenatal and Postpartum Care – Postpartum Care* measure reports the percentage of women who (a) delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, (b) were continuously enrolled at least 43 days prior to delivery through 56 days after delivery, and (c) received a postpartum visit on or between 21 days and 56 days after delivery.

Health Plan Ranking: Prenatal and Postpartum Care – Postpartum Care

Figure 4-10—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Prenatal and Postpartum Care – Postpartum Care



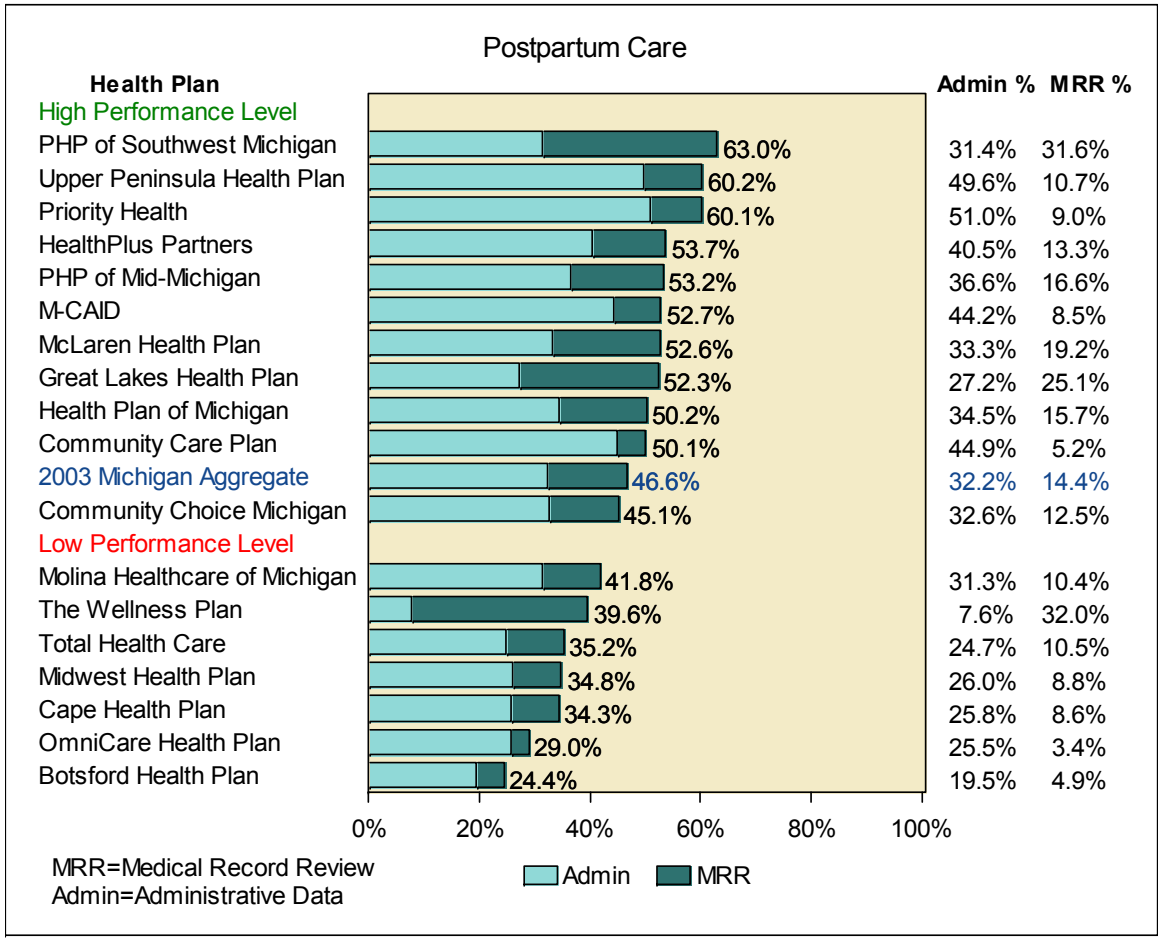
None of the health plans reported rates above the HPL of 65.6 percent, although three health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile. Seven health plans reported rates below the LPL of 44.0 percent.

The 2003 Michigan Medicaid weighted average of 44.9 percent was 0.9 percentage points above the LPL and 9.6 percentage points below the national HEDIS 2002 Medicaid 50th percentile of 54.5 percent. The reported rates ranged from a low of 24.4 percent to a high of 63.0 percent.

The *Postpartum Care* rate for the Michigan Medicaid weighted average declined 6.3 percentage points this year, as the rate changed from 51.2 percent in 2002 to 44.9 percent for 2003. The most significant change over the last year was the number of health plans that were above the HPL or below the LPL. In 2002, three health plans were below the LPL and two exceeded the HPL, compared with 2003, in which seven were below the LPL and none exceeded the HPL.

Data Collection Analysis: Prenatal and Postpartum Care – Postpartum Care

Figure 4-11—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Prenatal and Postpartum Care – Postpartum Care



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans elected to report this measure using the hybrid method. The 2003 Michigan aggregate administrative rate was 32.2 percent. The administrative rate range continues to be substantial, ranging from 7.6 percent to 51.0 percent, with 16 of the 18 health plans deriving more than half of their rate from administrative data.

This result demonstrates that 69.1 percent of the aggregate rate was derived from administrative data and 30.9 percent from medical record review. Last year, 73.6 percent of the aggregate rate was derived from administrative data. Overall, the 2003 Michigan aggregate rate increased 14.4 percentage points from medical record review. Like the *Timeliness of Prenatal Care* measure, identifying numerator events using administrative data are made difficult by such issues as capitation of maternity-related services and global billing. Therefore, medical record review is a benefit to this measure.

Women's Care Findings and Recommendations

The key findings indicate that:

- Performance in Women's Care is mixed. There was little change in cancer screening results compared to 2002, although there is statistically significant improvement in all rates for Chlamydia Screening in Women and poor performance in prenatal and postpartum care.
- Maternal care is a major area of concern in the Michigan Medicaid 2003 results. Both the Timeliness of Prenatal Care and Postpartum Care aggregate rates are below the national HEDIS 2002 Medicaid 50th percentile, with the Postpartum Care rate less than one percentage point above the 25th percentile. In addition, the aggregate rates for both measures show a decrease when compared to 2002 rates.
- Administrative data reporting is improving, except for the maternity care measures.

The 2003 Michigan Medicaid weighted average for *Breast Cancer Screening* was just one-tenth of a percentage point below the national HEDIS 2002 Medicaid 50th percentile. All of the health plans derived more than 90 percent of their rate from administrative data, indicating that administrative data for this HEDIS measure is complete. The trend for the *Breast Cancer Screening* rate, however, has not shown any significant change compared to 2001 and 2002. Improvements for this measure should focus on member education.

For *Cervical Cancer Screening*, the 2003 Michigan Medicaid weighted average was identical to the national HEDIS 2002 Medicaid 50th percentile. The rate for the *Cervical Cancer Screening* has improved by 7.0 percentage points since 2001. Overall, 89.1 percent of the rate was derived from administrative data, which was an improvement of 7.8 percentage points from 2002.

The 2003 Michigan Medicaid weighted average for the *Chlamydia Screening in Women – Combined Rate* (all age groups) was 5.7 percentage points higher than the national HEDIS 2002 Medicaid 50th percentile. The trend for the rate for *Chlamydia Screening in Women – Combined* has gained 11.1 percentage points since 2001.

For *Timeliness of Prenatal Care*, the 2003 Michigan Medicaid weighted average was 8.0 percentage points below the national HEDIS 2002 Medicaid 50th percentile. The *Timeliness of Prenatal Care* rate for the Michigan Medicaid weighted average declined 5.8 percentage points this year. All 18 health plans chose to use the hybrid method for this measure, and 51.9 percent of the rate was derived using administrative data. Compared to the *Breast Cancer Screening* measure, administrative data for *Timeliness of Prenatal Care* is largely incomplete.

For *Postpartum Care,* the 2003 Michigan Medicaid weighted average was 9.6 percentage points below the national HEDIS 2002 Medicaid 50th percentile, a decline of 6.3 percentage points from 2002. This measure was similar to *Timeliness of Prenatal Care,* where all 18 health plans chose to use the hybrid method, and 69.1 percent of the rate was derived using administrative data, again indicating that administrative data for maternity-related services are largely incomplete.

Given the lack of robust improvement by the Michigan Medicaid health plans in the area of maternal care, HSAG recommends that MDCH and the health plans should consider additional research to determine if there are specific barriers to maternal care or if non-compliance is the result of a lack of member knowledge regarding the value of these visits. In addition, targeted interventions focusing efforts on each of the measures can be very effective. Below, HSAG identifies other interventions that have been successful in bringing about improvement in reported rates.

Improving the rates for *Timeliness of Prenatal Care* and *Postpartum Care* may require a combination of interventions, rather than one quality improvement project at the health plan level. Global billing for maternity care hinders the ability to report these measures using the administrative method. However, Medicaid health plans in other states have strategically improved their rates using the following methods:

- For some health plans, the Utilization Management department actively engages in the coordination of care provided to pregnant women. This may include a hospital visit at the time of delivery to meet with the mother, discuss the importance of a postpartum visit, and give her an incentive coupon to be redeemed once she receives her postpartum visit. Reminder postcards can be sent to the mother a week later. Health plans using this strategy have achieved rates above 70 percent for postpartum care, in contrast with the current Michigan Medicaid weighted average of 44.9 percent.
- Health plans may change from global billing to fee-for-service, or offer providers a bonus incentive to submit encounter data. This can result in an increase in the submission of claims and encounter data, which reduces the amount of medical records the health plans needs to pursue. The savings in medical record pursuit and abstraction can be greater than the increased fees paid to providers.
- The most successful strategies often include a combined approach. Strategies such as implementing an incentive program for members, capturing each individual prenatal care visit on the global bill within the claims system, and rewarding providers to use a health plan-developed form that captures all the required elements of a prenatal and postpartum care visit work well independently. However, these interventions can achieve more drastic improvement when administered concurrently. Some health plans have arranged for providers to offer the pregnant women coupons or certificates after completing each required visit. The coupons had to be signed by the providers and then sent by the members to the health plan for redemption. This improved administrative data completeness and member compliance.

We recommend that the health plans focus their attention on *Timeliness of Prenatal Care* and *Postpartum Care*. Improving these rates usually impacts the *Chlamydia Screening in Women* rates as well, since this screening is typically performed as part of a prenatal care visit.

Breast Cancer Screening and *Cervical Cancer Screening* may require increased member education to improve these rates. All women in the appropriate age groups should receive reminder postcards. Newsletters have been shown to improve rates to a smaller degree. Outreach programs have also demonstrated some success.

Introduction

Chronic illness afflicts 100 million Americans and accounts for 70 percent of all health care spending. The measures in this section (asthma, diabetes, and smoking) focus on how health plans ensure those with ongoing, chronic conditions take care of themselves, control symptoms, avoid complications, and maintain daily activities. Comprehensive programs implemented by health plans can help reduce the prevalence, impact, and economic costs associated with these chronic illnesses.

Asthma rates are increasing nationwide and the impact on health and the economy is substantial. Recent analysis of the economic impact of asthma, commissioned by the American Lung Association to study asthma costs, cited annual estimated costs in 2000 and 2001 of $12.7 billion and $14 billion, respectively.[5-1] According to the most recent data available for the State of Michigan, more than 534,000 of all adults suffered from asthma, or 7.2 percent of the population.[5-2] However, lifetime prevalence rates in Michigan rise to as high as 15.6 percent for adults with family incomes less than $15,000.[5-3]

The prevalence of diabetes increases with age and is higher among certain racial and ethnic minority populations. The growth, aging, and increasing racial and ethnic diversity of the U.S. population indicates a significant increase in the size of the population with diabetes. If diabetes prevalence rates remained steady over time, controlling for age, sex, race, and ethnicity, the annual cost in 2002 dollars of diabetes could rise to a projected $156 billion by 2010 and $192 billion by 2020.[5-4]

Diabetes prevalence, mortality, and complication rates associated with diabetes have also increased steadily in Michigan and in the nation over the last decade. Michigan average data (1999-2001) indicate that 485,000 adults and 6,200 persons under the age of 18 have been diagnosed with diabetes.[5-5] Diabetes costs Michigan residents $3.5 billion a year in lost productivity due to premature death, disability, and illness.[5-6]

High blood pressure affects approximately 50 million adults in the United States, roughly one quarter of the adult population. It can cause heart attacks, heart failure, stroke, kidney disease, and other serious problems. Only one-third of people with high blood pressure are even aware that they have the disease because they do not have the warning signs and have not been screened, according to the U.S. Preventive Services Task Force.[5-7] The risk of developing high blood pressure increases

[5-1] American Lung Association Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality.* March 2003.
[5-2] American Lung Association of Michigan. Asthma in Adults; 2001. Available at: http://www.getasthmahelp.org/stats_adult.asp.
[5-3] Ibid.
[5-4] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2002. *Diabetes Care 2003*. Available at: http://care.diabetesjournal.org.
[5-5] Assistant Secretary for Health, U.S. Department of Health and Human Services. Comprehensive Diabetes Control Program, Michigan Department of Community Health; 2002. Best Practice Initiative, Office of Public Health and Science. Available at: http://phs.os.dhhs.gov/ophs/BestPractice/MI.htm.
[5-6] Diabetes in Michigan, Michigan Department of Community Health: Diabetes, Kidney and Other Chronic Diseases Section, May 2002. Available at: http://www.michigan.gov/mdch/1,1607,7-132-2940_2955_2980-13768--,00.html.
[5-7] Agency for Healthcare Quality and Research (AHRQ). Prevention Experts Urge High Blood Pressure Screening for All Adults Age 18 and Older [press release]; July 14, 2003. Available at: http://www.ahrq.gov/news/press/pr2003/highbppr.htm. Accessed on September 8, 2003.

with age. In fact, people with normal blood pressure at age 55 still have a 90 percent risk for developing high blood pressure in their lifetime.[5-8]

Cigarette smoking kills about half of all continuing smokers, and is the most preventable cause of premature death in the United States. According to the American Cancer Society, about 430,000 deaths from smoking are expected in any given year.[5-9] Yet, about 25 percent of all American adults smoke and prevalence among adolescents has risen dramatically over the past decade. Smoking is the major cause of many cancers, as well as other serious diseases, including heart disease, bronchitis, emphysema, and strokes. Most smokers make several attempts to quit and, according to the U.S. Surgeon General, 46 percent of smokers try to quit each year.[5-10] Assistance with smoking cessation is extremely cost effective compared to the estimated $50 billion of annual medical care costs related to smoking or smoking-related diseases. The U.S. Public Health Service issued a clinical practice guideline for treating tobacco use and dependence (June 2000). It estimated that it would cost $6.3 billion each year to provide 75 percent of smokers over age 18 with a counseling and/or medication intervention for smoking cessation. This would result in an estimated 1.7 million new quitters at an average cost of $3,779 per quitter.[5-11]

The Living with Illness dimension encompasses the following MDCH Key Measures:

- **Comprehensive Diabetes Care**
  - *Comprehensive Diabetes Care – HbA1c Testing*
  - *Comprehensive Diabetes Care – Poor HbA1c Control*
  - *Comprehensive Diabetes Care – Eye Exam*
  - *Comprehensive Diabetes Care – LDL-C Screening*
  - *Comprehensive Diabetes Care – LDL-C Level*
  - *Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy*
- **Use of Appropriate Medications for People with Asthma**
  - *Use of Appropriate Medications for People with Asthma – Ages 5 to 9 Years*
  - *Use of Appropriate Medications for People with Asthma – Ages 10 to 17 Years*
  - *Use of Appropriate Medications for People with Asthma – Ages 18 to 56 Years*
  - *Use of Appropriate Medications for People with Asthma – Combined Rate*
- **Controlling High Blood Pressure**
- **Medical Assistance with Smoking Cessation – Advising Smokers to Quit**

The following pages provide detailed analysis of Michigan Medicaid health plan performance and ranking, as well as data collection methodology for these measures.

[5-8] National Institutes of Health Web site. Available at: http://hin.nhlbi.nih.gov/nhbpep_slds/jnc/slides/part1/img006.gif. Accessed on September 8, 2003.

[5-9] American Cancer Society. Health Information Seekers – Cigarette Smoking Tobacco-related Diseases Kill Half of All Smokers; 2003. Available at: http://www.cancer.org/docroot/PED/content/PED_10_2X_Cigarette_Smoking_and_Cancer.asp?sitearea=PED. Accessed on September 5, 2003.

[5-10] U.S. Public Health Service. Treating Tobacco Use and Dependence. Fact Sheet; June 2000. Available at: http:www.surgeongeneral.gov/tobacco/smokfact.htm. Accessed on September 5, 2003.

[5-11] U.S. Public Health Service. Treating Tobacco Use and Dependence—A Systems Approach. A Guide for Health Care Administrators, Insurers, Managed Care Organizations, and Purchasers; November 2000. Available at: http://www.surgeongeneral.gov/tobacco/systems.htm. Accessed on September 5, 2003.

Comprehensive Diabetes Care

Approximately 16 million Americans have diabetes, the sixth leading cause of death by disease in the United States, and 798,000 new cases are diagnosed annually. In Michigan, 524,000 people were newly diagnosed with diabetes in 2001.[5-12] Control of diabetes significantly reduces the rate of complications and improves quality of life for diabetics. The World Health Organization (WHO) estimates that the total health care costs of a person with diabetes in the United States are three times those for people without the condition.

Diabetes is a complex disease that affects multiple organs, which can sometimes lead to additional chronic conditions such as heart disease, blindness, kidney disease, stroke, and even death. It is estimated that, for every 1 percent reduction in blood glucose levels, the risk of developing eye or kidney/end-stage renal disease, and for requiring lower-extremity amputation, drops by 40 percent.[5-13] Therefore, a comprehensive assessment of diabetes care necessitates examination of multiple factors. This measure contains a variety of indicators, each of which provides a critical element of information. These indicators are consistent with the Diabetes Quality Improvement Project (DQIP) set of measures (excluding hypertension and foot care). The DQIP is a national quality of care project sponsored by the Centers for Medicare & Medicaid Services (CMS), the American Diabetic Association (ADA), the FACCT, and NCQA. When taken together, the components build a comprehensive picture that permits a better understanding of the quality of diabetes care.

The *Comprehensive Diabetes Care* measure is reported using six separate rates: (1) *HbA1c Testing*, (2) *Poor HbA1c Control*, (3) *Eye Exam*, (4) *LDL-C Screening*, (5) *LDL-C Level*, and (6) *Monitoring for Diabetic Nephropathy*.

The following pages show in detail the performance profile, health plan rankings, and analysis of data collection methodology used by the Michigan Medicaid health plans for each of these measures.

HEDIS Specification: Comprehensive Diabetes Care – HbA1c Testing

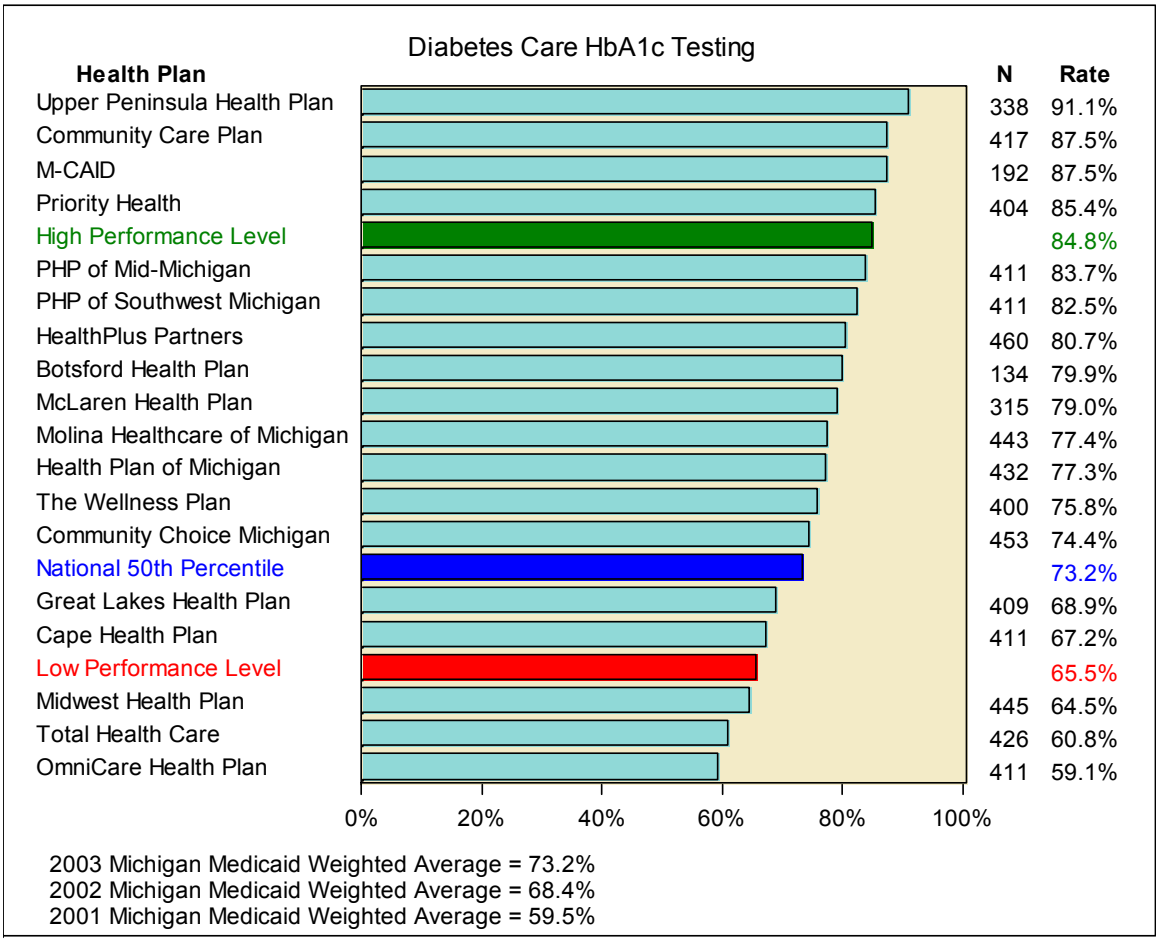
The *Comprehensive Diabetes Care—HbA1c Testing* rate reports the percentage of members with diabetes (Type 1 and Type 2) aged 18 through 75 years, who were continuously enrolled during the measurement year and had one or more HbA1c test(s) conducted during the measurement year identified through either administrative data or medical record review.

[5-12] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Statistics: Diabetes Surveillance System, Prevalence of Diabetes, 1994-2002. Available at: www.cdc.gov/diabetes/statistics/prev/state/ Table15.htm.

[5-13] National Committee for Quality Assurance. *The State of Health Care Quality 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003: p. 34.

Health Plan Ranking: Comprehensive Diabetes Care – HbA1c Testing

Figure 5-1—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Comprehensive Diabetes Care – HbA1c Testing

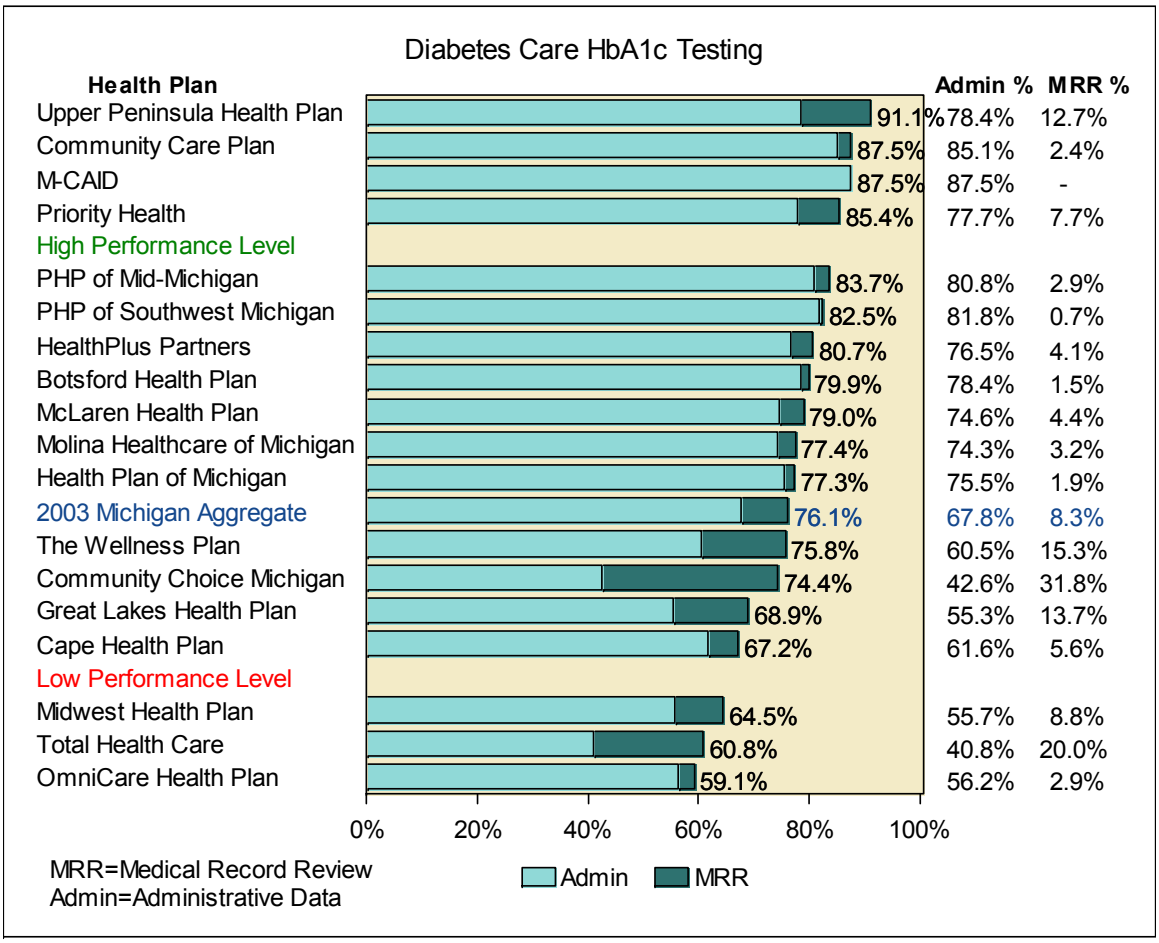


Four of the health plans had reported rates above the HPL, while three health plans had rates below the LPL. A total of 13 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 73.2 percent matched the national HEDIS 2002 Medicaid 50th percentile rate, and was higher than the 2002 Michigan Medicaid weighted average of 68.4 percent. The 18 reported rates ranged from 59.1 percent to 91.1 percent. Denominator sizes ranged from 134 to 460. The Michigan Medicaid weighted average gain in 2003, of 4.8 percentage points, was not statistically significant.

Data Collection Analysis: Comprehensive Diabetes Care – HbA1c Testing

Figure 5-2—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Comprehensive Diabetes Care – HbA1c Testing



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Seventeen of the 18 health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate for this measure was 67.8 percent.

This result demonstrates that 89.1 percent of the aggregate rate was derived from administrative data and 10.9 percent from medical record review. Last year, 74.9 percent of the aggregate rate was derived from administrative data. Overall, the 2003 Michigan aggregate rate increased by 8.3 percentage points by using medical record review. Five health plans demonstrated substantial improvement in their rate from medical record review, of more than 10 percentage points.

Comprehensive Diabetes Care – Poor HbA1c Control

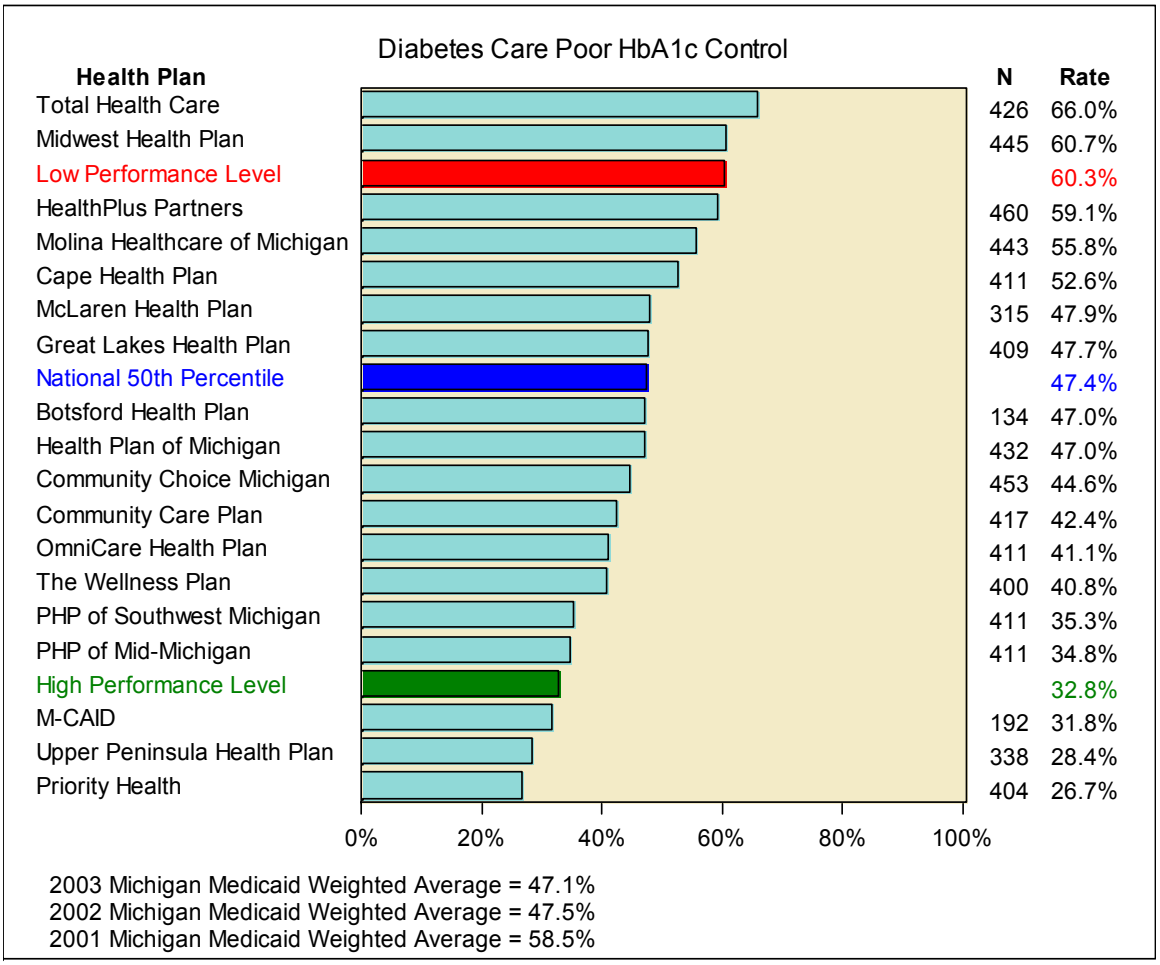
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, end-stage renal disease, and lower extremity amputation.

HEDIS Specification: Comprehensive Diabetes Care – Poor HbA1c Control

The *Comprehensive Diabetes Care—Poor HbA1c Control* rate reports the percentage of members with diabetes (Type 1 and Type 2) aged 18 through 75 years, who were continuously enrolled during the measurement year and whose most recent HbA1c test(s) conducted during the measurement year showed a greater than 9.5 percent HbA1c level, as documented through automated laboratory data and/or medical record review. If there is no HbA1c level during the measurement year, the level is considered to be greater than 9.5 (that is, "no test" is counted as poor HbA1c control.)

Health Plan Ranking: Comprehensive Diabetes Care – Poor HbA1c Control

Figure 5-3—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Comprehensive Diabetes Care – Poor HbA1c Control



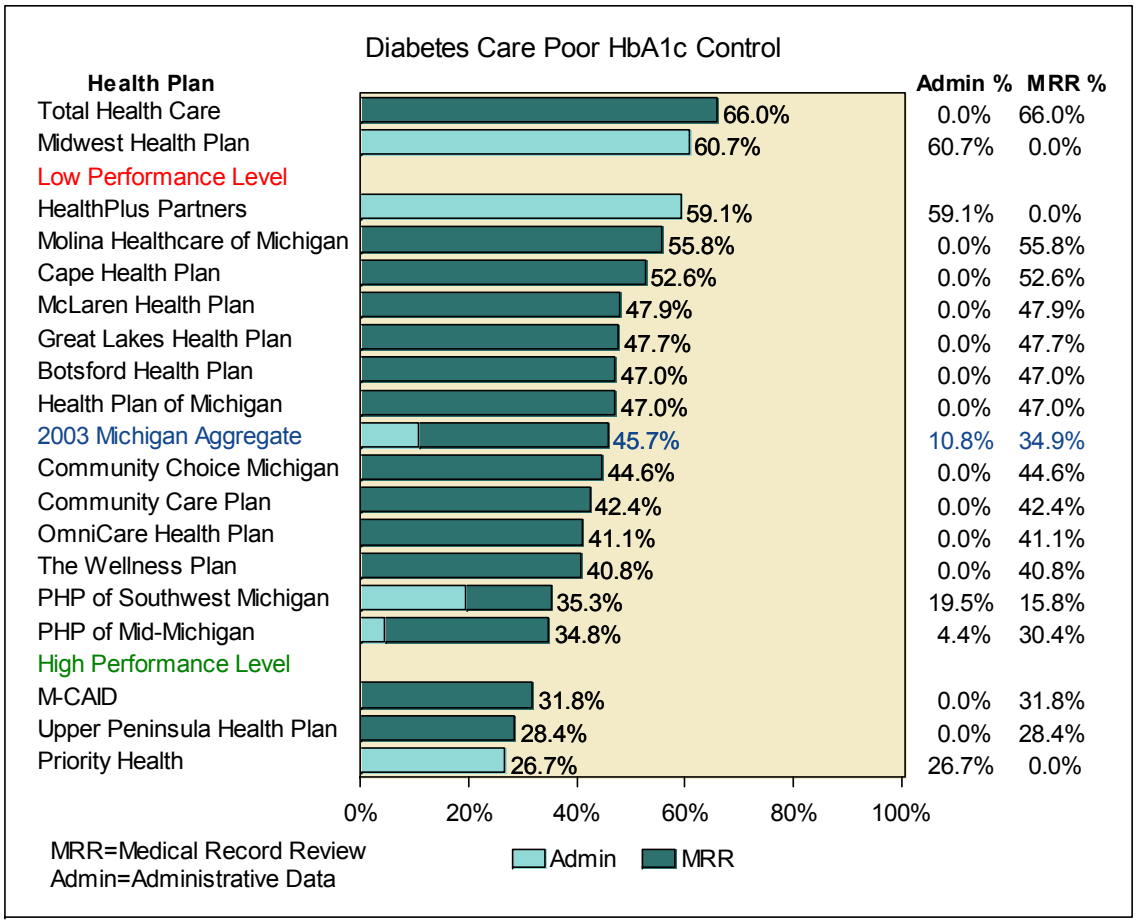
For this Key Measure, a *lower* rate indicates *better* performance, since low rates of *Poor HbA1c Control* indicate better care.

Three health plans had reported rates that exceeded the HPL, while two health plans had rates below the LPL. A total of 11 health plans reported rates lower than the national HEDIS 2002 Medicaid 50th percentile, indicating better performance. The 18 reported rates ranged from 26.7 percent to 66.0 percent. Denominator sizes ranged from 134 to 460.

The 2003 Michigan Medicaid weighted average of 47.1 percent showed a slight improvement when compared to the 2002 Michigan Medicaid weighted average of 47.5 percent. For this measure, a *lower* rate indicates better performance. The 2003 Michigan Medicaid weighted average was also just under the national HEDIS 2002 Medicaid 50th percentile rate of 47.4 percent.

Data Collection Analysis: Comprehensive Diabetes Care – Poor HbA1c Control

Figure 5-4—Michigan Medicaid HEDIS 2003 Data Collection Analysis: Comprehensive Diabetes Care – Poor HbA1c Control



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

For this Key Measure, a *lower* rate indicates *better* performance, since low rates of *Poor HbA1c Control* indicate better care.

Figure 5-4 displays the breakout of rates that were derived from administrative data and medical record review for this measure. This measure examines *Poor HbA1c Control* and in this case, a *lower* rate indicates better performance.

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate for this measure was 10.8 percent. Three health plans derived their rates completely through administrative data, while two health plans derived a portion of their total rate from administrative data.

This result demonstrates that, overall, 23.6 percent of the aggregate rate was derived from administrative data and 76.4 percent from medical record review. Last year, 16.4 percent of the aggregate rate was derived from administrative data.

For this measure, results demonstrate that few health plans have the ability to capture laboratory values administratively with their claims system, or that laboratory vendors do not regularly provide this level of detailed information.

Comprehensive Diabetes Care – Eye Exam

Diabetic retinopathy causes up to 24,000 new cases of blindness every year. Blindness in diabetics under the age of 65 costs the federal government more than $14,000 annually for each affected person, while screening for diabetic retinopathy has been estimated to cost about $31 per patient.[5-14]

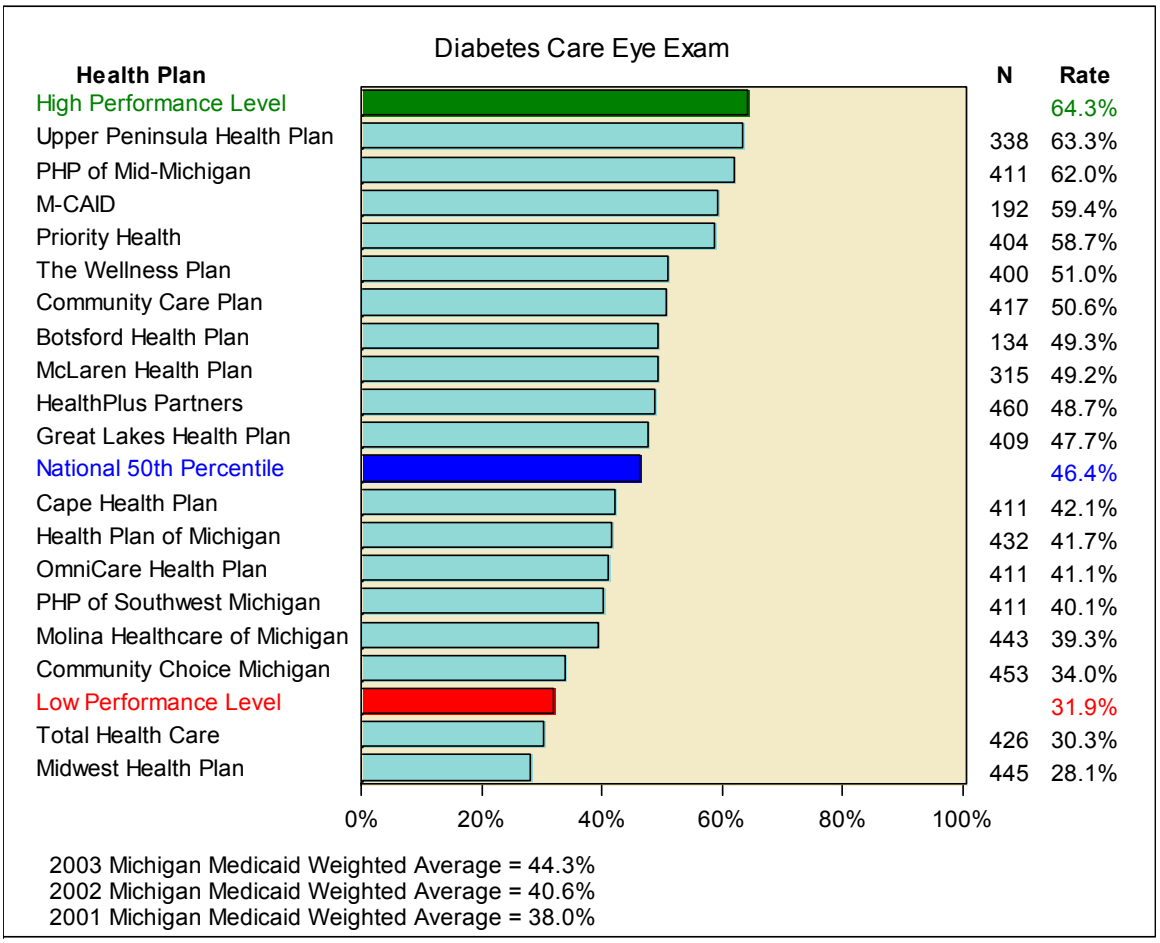
HEDIS Specification: Comprehensive Diabetes Care – Eye Exam

The *Comprehensive Diabetes Care – Eye Exam* rate reports the percentage of members with diabetes (Type 1 and Type 2) aged 18 through 75 years, who were continuously enrolled during the measurement year and who had an eye screening for diabetic retinal diseases (that is, a retinal exam by an eye care professional), as documented through either administrative data or medical record review.

[5-14] National Committee for Quality Assurance. *The State of Managed Care Quality. 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:47-8.

Health Plan Ranking: Comprehensive Diabetes Care – Eye Exam

Figure 5-5—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Comprehensive Diabetes Care – Eye Exam

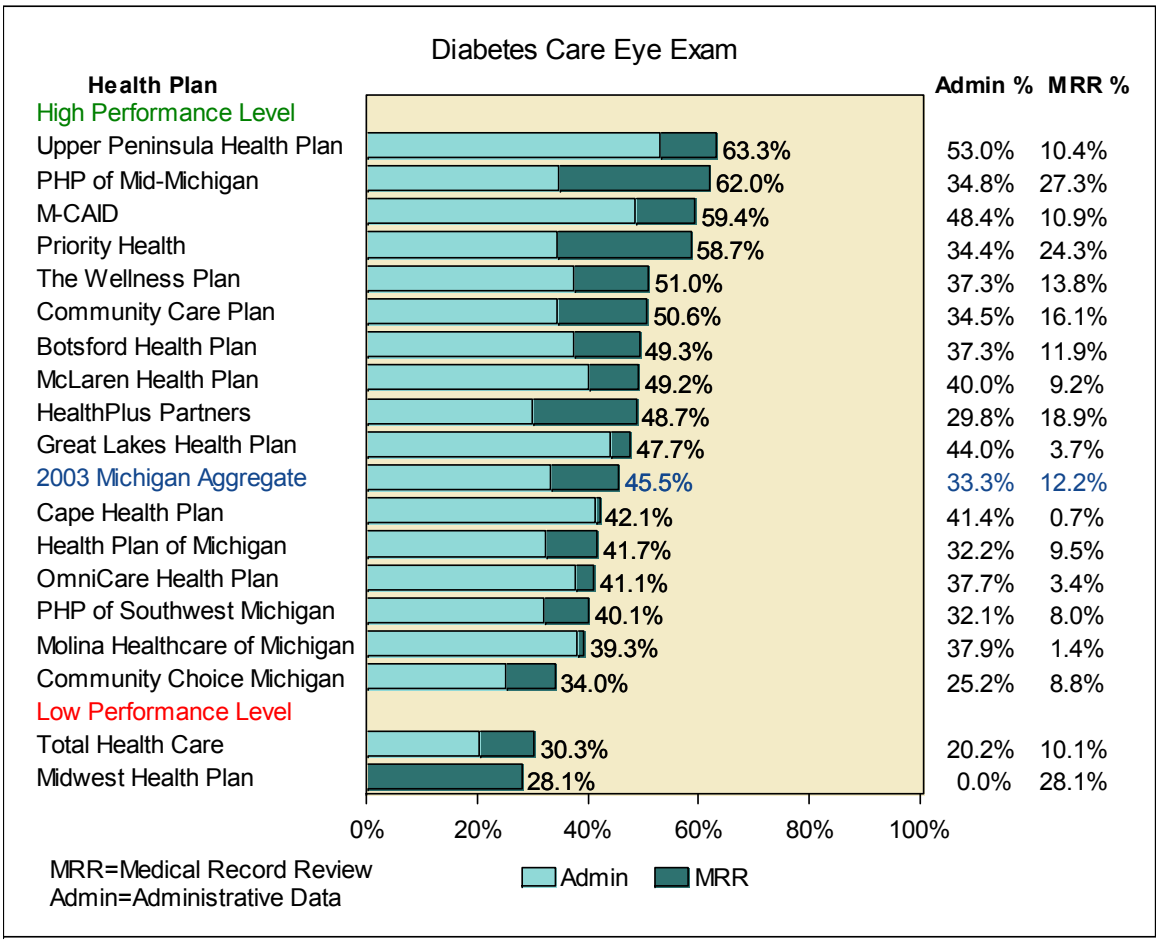


None of the health plans had reported rates that exceeded the HPL, while two health plans had rates below the LPL. A total of 10 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile. The 18 reported rates ranged from 28.1 percent to 63.3 percent. Denominator sizes ranged from 134 to 460.

The 2003 Michigan Medicaid weighted average of 44.3 percent was lower than the national HEDIS 2002 Medicaid 50th percentile of 46.4 percent, while higher than the 2002 Michigan Medicaid weighted average of 40.6 percent. The Michigan Medicaid weighted average gain in 2003, of 3.7 percentage points, was not statistically significant.

Data Collection Analysis: Comprehensive Diabetes Care – Eye Exam

Figure 5-6—Michigan Medicaid HEDIS 2003 Data Collection Analysis: Comprehensive Diabetes Care – Eye Exam



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate for this measure was 33.3 percent. With the exception of one health plan (Midwest Health Plan), more than half of the total rate for each health plan was derived from administrative data. Overall, 73.2 percent of the aggregate rate was derived from administrative data and 26.8 percent from medical record review. Last year, 77.2 percent of the aggregate rate was derived from administrative data.

The 2003 Michigan aggregate rate increased by 12.2 percentage points by using medical record review. Ten health plans demonstrated substantial improvement in their rate from medical record review, of more than 10 percentage points.

Comprehensive Diabetes Care – LDL-C Screening

LDL is a type of lipoprotein that carries cholesterol in the blood. LDL is considered to be undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to "hardening of the arteries" and heart disease. Hence, LDL cholesterol is often termed "bad" cholesterol. The test for LDL measures the amount of LDL cholesterol in blood.[5-15]

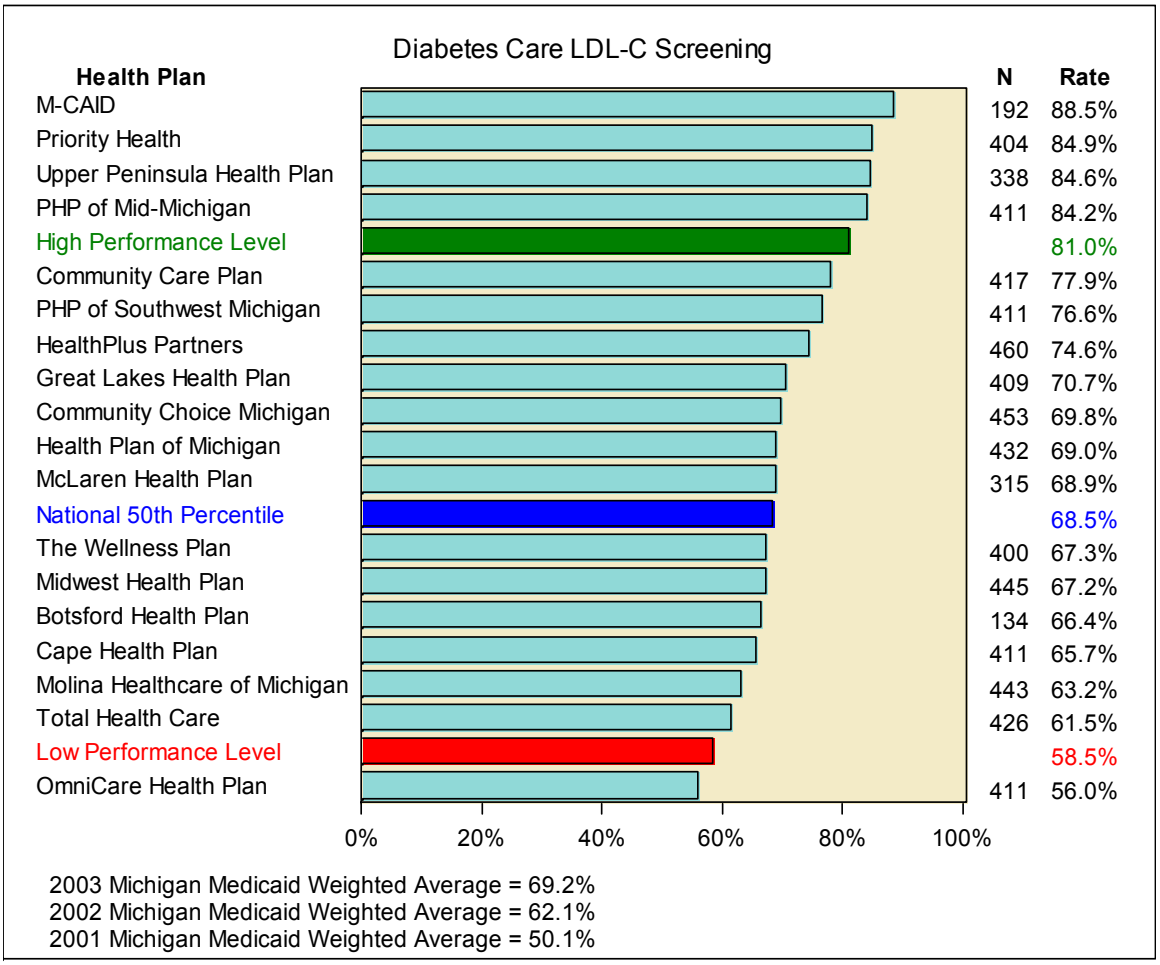
HEDIS Specification: Comprehensive Diabetes Care – LDL-C Screening

The *Comprehensive Diabetes Care—LDL-C Screening* rate reports the percentage of members with diabetes (Type 1 and Type 2) aged 18 through 75 years, who were continuously enrolled during the measurement year and who had an LDL-C test during the measurement year or year prior to the measurement year as determined by claims/encounters, automated laboratory data, or medical record review.

[5-15] Kramer Robert J, MD, FACC, FCCP. Cholesterol Blood Test. Heart Center Online for Patients. HeartCenterOnline, Inc. 2000-2002. Review date: August 15, 2001. Available at: http://www.heartcenteronline.com/myheartdr/common/articles.cfm?ARTID=607. Accessed on October 20, 2003.

Health Plan Ranking: Comprehensive Diabetes Care – LDL-C Screening

Figure 5-7—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Comprehensive Diabetes Care – LDL-C Screening

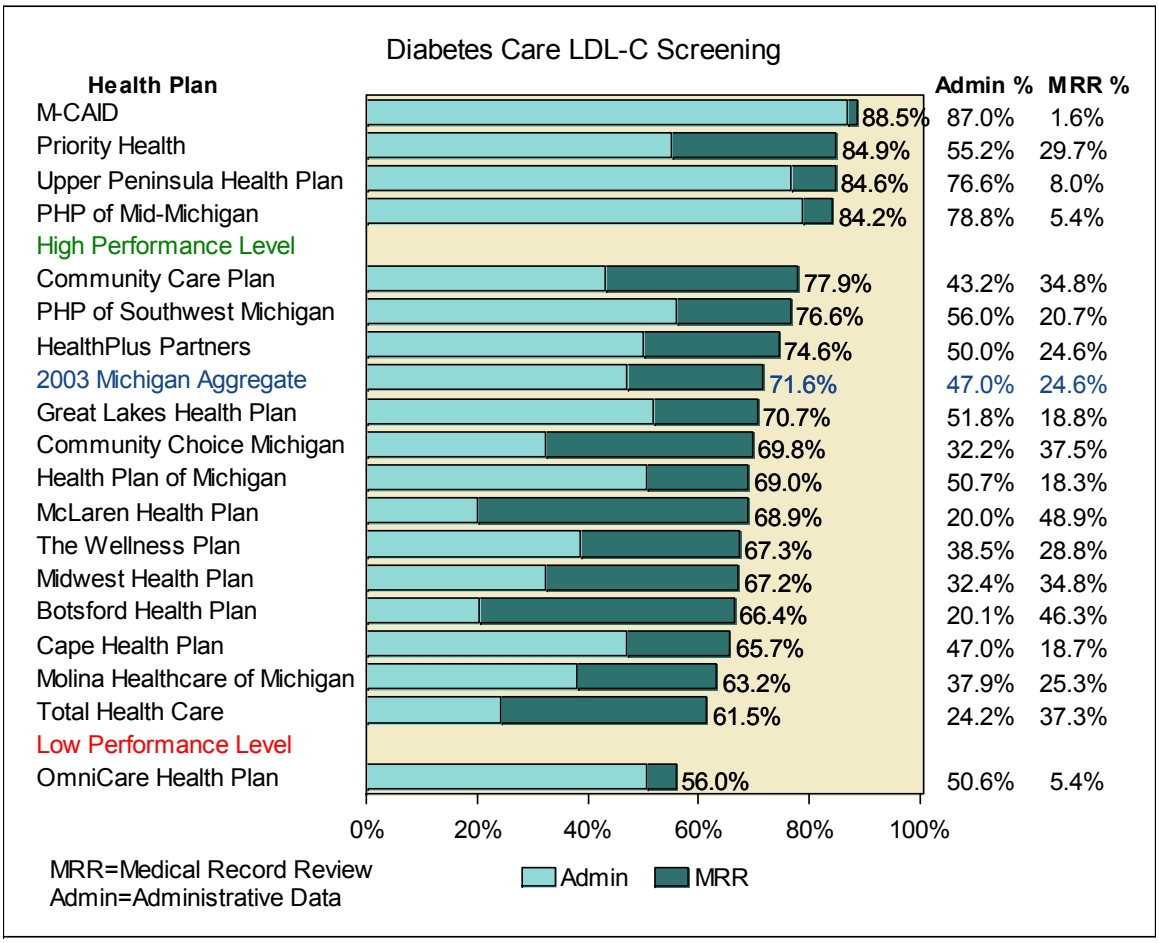


Four of the health plans had reported rates above the HPL, while one health plan (OmniCare Health Plan) had a rate below the LPL. A total of 11 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 69.2 percent was just above the national HEDIS 2002 Medicaid 50th percentile rate of 68.5 percent and higher than the 2002 Michigan Medicaid weighted average of 62.1 percent. The Michigan Medicaid weighted average gain in 2003, of 7.1 percentage points, was statistically significant. The 18 reported rates ranged from 56.0 percent to 88.5 percent. Denominator sizes ranged from 134 to 460.

Data Collection Analysis: Comprehensive Diabetes Care – LDL-C Screening

Figure 5-8—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Comprehensive Diabetes Care – LDL-C Screening



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate for this measure was 47.0 percent. Thirteen health plans each derived more than half of their rate from administrative data. Overall, 65.6 percent of the aggregate rate was derived from administrative data and 34.4 percent from medical record review. Last year, 53.0 percent of the aggregate rate was derived from administrative data.

The 2003 Michigan aggregate rate increased by 24.6 percentage points by using medical record review. Fourteen health plans had substantial improvements from medical record review of more than 10 percentage points in their rate, ranging from 18.3 percent to 48.9 percent.

Comprehensive Diabetes Care – LDL-C Level

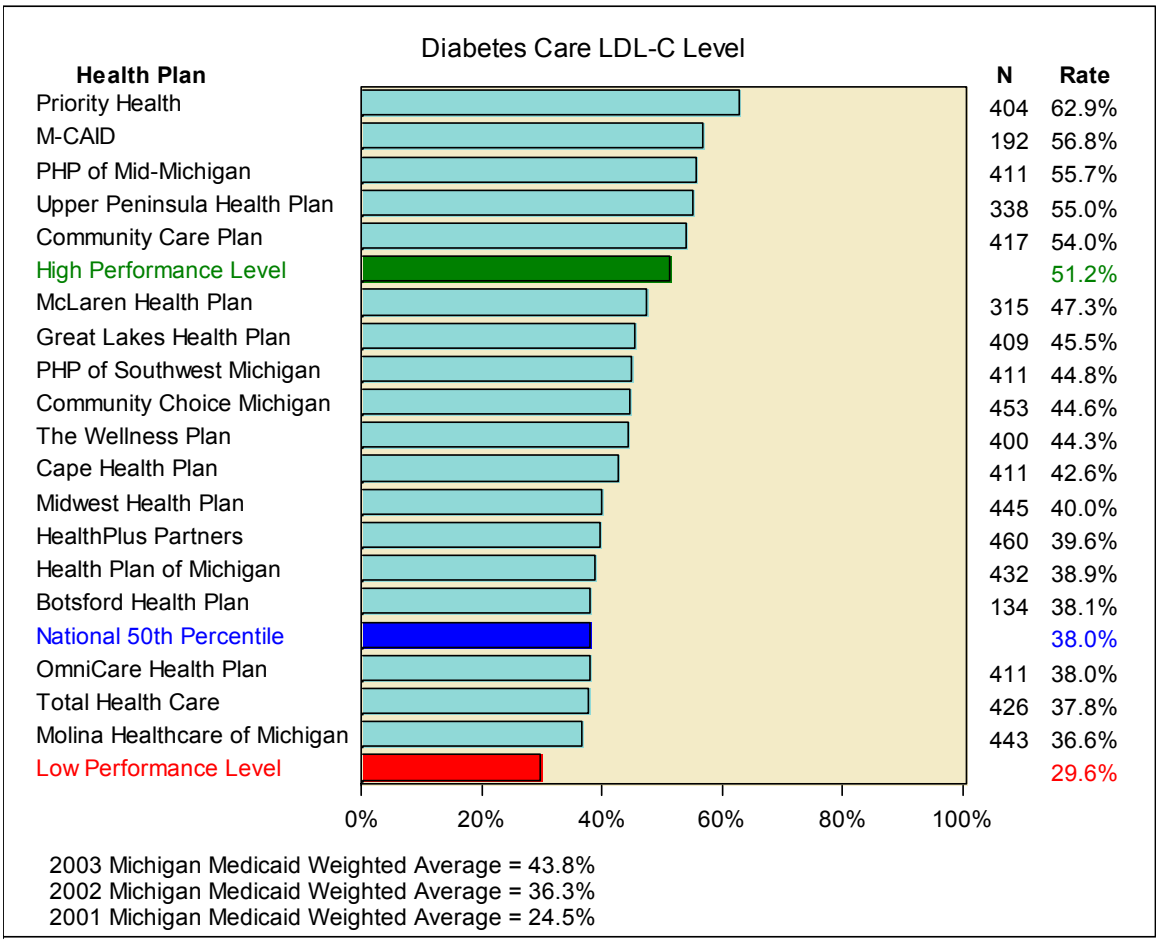
This measure indicates the percentage of members whose most recent LDL-C test shows that the level of LDL cholesterol in the blood is under control.

HEDIS Specification: Comprehensive Diabetes Care – LDL-C Level

The rate for *Comprehensive Diabetes Care—LDL-C Level* calculates the percentage of members with diabetes (Type 1 and Type 2) aged 18 through 75 years, who were continuously enrolled during the measurement year and whose most recent LDL-C test (performed during the measurement year or the year prior to the measurement year) indicated an LDL-C level less than 130 mg/dL, as documented through automated laboratory data and/or medical record review. If there is no valid LDL-C level within the last two measurement years, the level is considered to be greater than 130 mg/dL.

Health Plan Ranking: Comprehensive Diabetes Care – LDL-C Level

Figure 5-9—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Comprehensive Diabetes Care – LDL-C Level

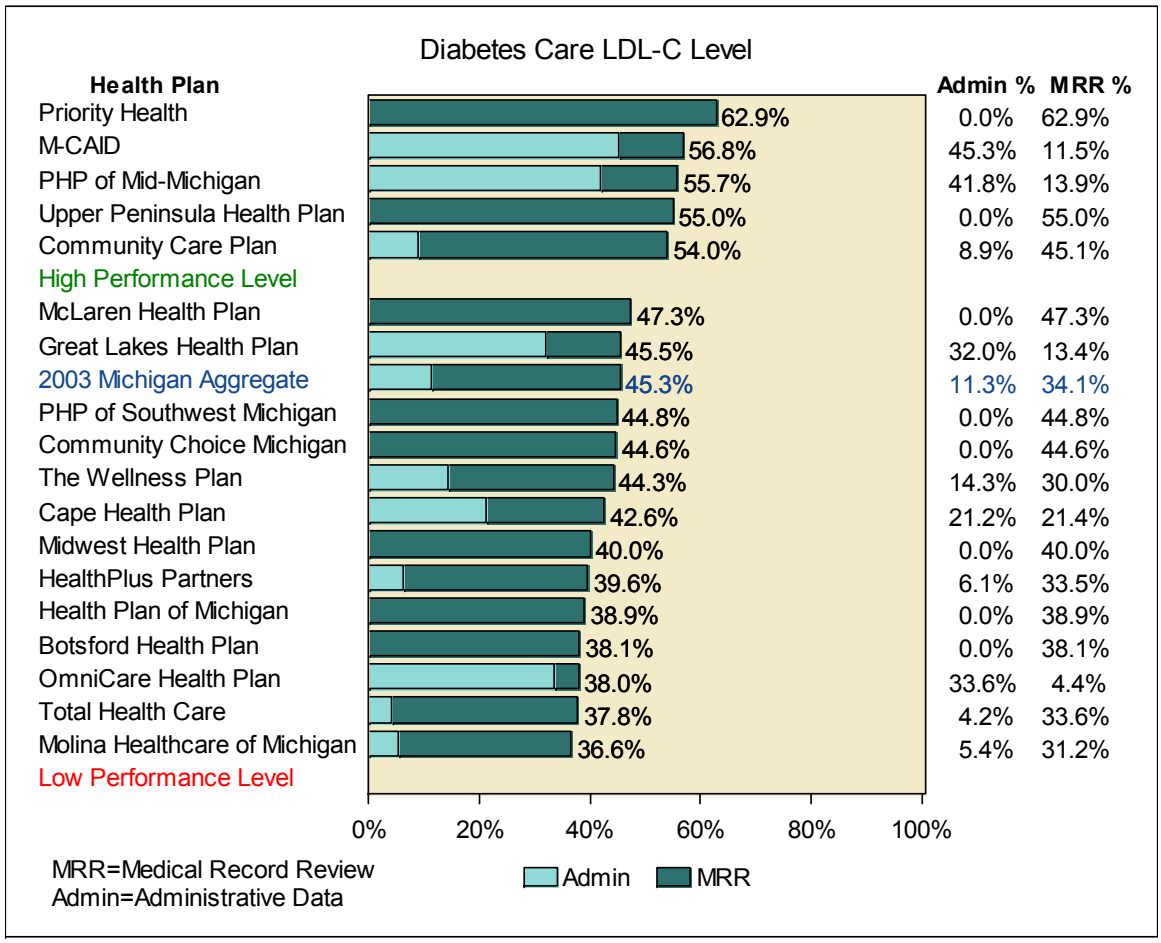


Five health plans had reported rates that exceeded the HPL, while none of the health plans had rates below the LPL. A total of 15 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 43.8 percent was higher than both the national HEDIS 2002 Medicaid 50th percentile rate of 38.0 percent and the 2002 Michigan Medicaid weighted average of 36.3 percent. The Michigan Medicaid weighted average gain in 2003, of 7.5 percentage points, was statistically significant. The 18 reported rates ranged from 36.6 percent to 62.9 percent. Denominator sizes ranged from 134 to 460.

Data Collection Analysis: Comprehensive Diabetes Care – LDL-C Level

Figure 5-10—Michigan Medicaid HEDIS 2003 Data Collection Analysis: *Comprehensive Diabetes Care – LDL-C Level*



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate for this measure was 11.3 percent. Only four health plans derived more than half of their rate from administrative data. Overall, 24.9 percent of the aggregate rate was derived from administrative data and 75.1 percent from medical record review. Last year, 16.6 percent of the aggregate rate was derived from administrative data.

Overall, the 2003 Michigan aggregate rate increased by 34.1 percentage points using medical record review. Results identified eight health plans with rates derived entirely from medical record review. This measure requires actual laboratory values that are not generally captured on claims or encounter forms.

Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy

Diabetes is a major cause of kidney disease, and the leading cause of end-stage renal disease (ESRD), accounting for about 40 percent of newly diagnosed cases.[5-16] About 100,000 Americans have kidney failure as a result of uncontrolled diabetes.

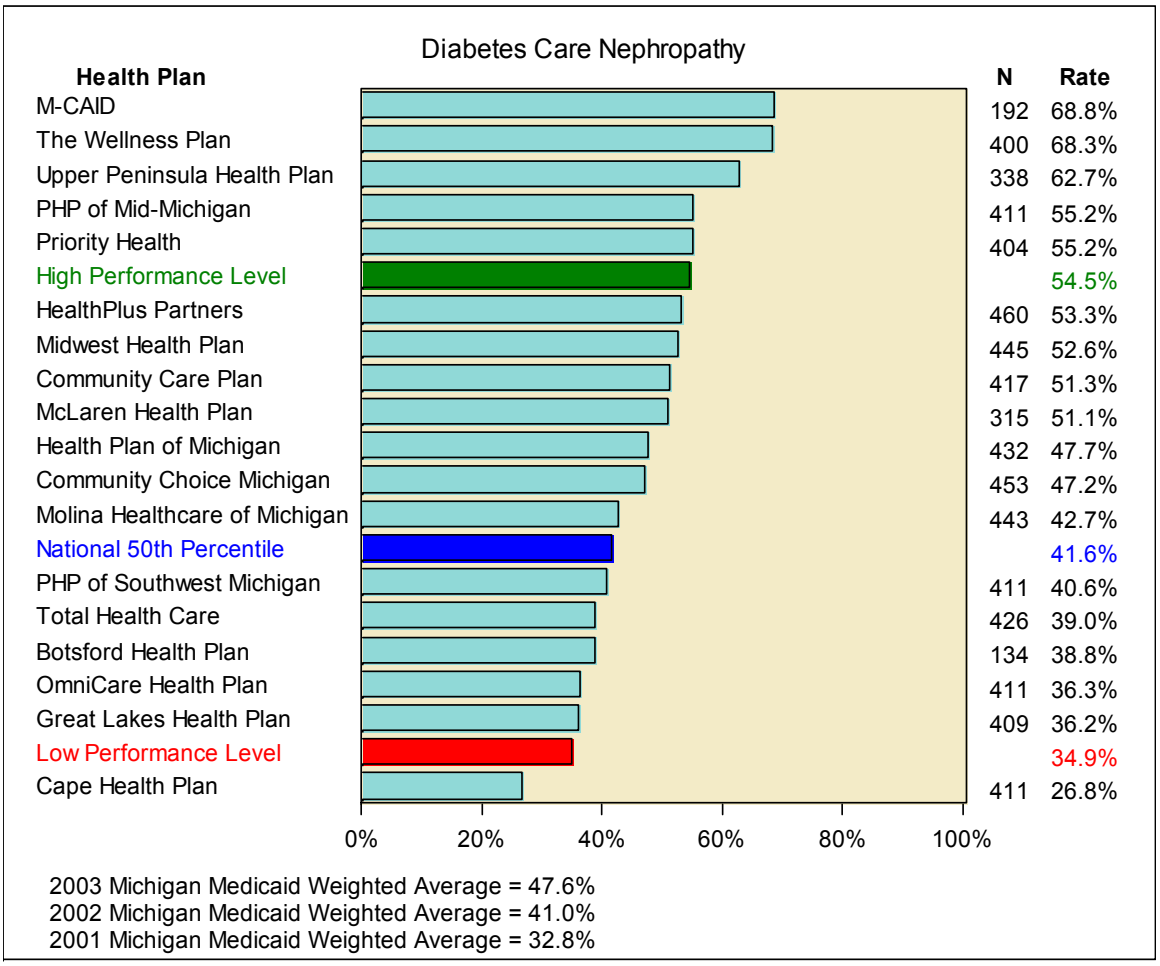
HEDIS Specification: Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy

The *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy* rate is intended to assess whether diabetic patients are being monitored for nephropathy. It reports the percentage of members with diabetes (Type 1 and Type 2) age 18 through 75 years old, who were continuously enrolled during the measurement year and who were screened for nephropathy, or received treatment for nephropathy, as documented through either administrative data or medical record review. The rate includes patients who have been screened for nephropathy, or who already have evidence of nephropathy as demonstrated by medical attention for nephropathy or a positive microalbuminuria test.

[5-16] National Committee for Quality Assurance. *The State of Managed Care Quality. 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:47.

Health Plan Ranking: Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy

Figure 5-11—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy

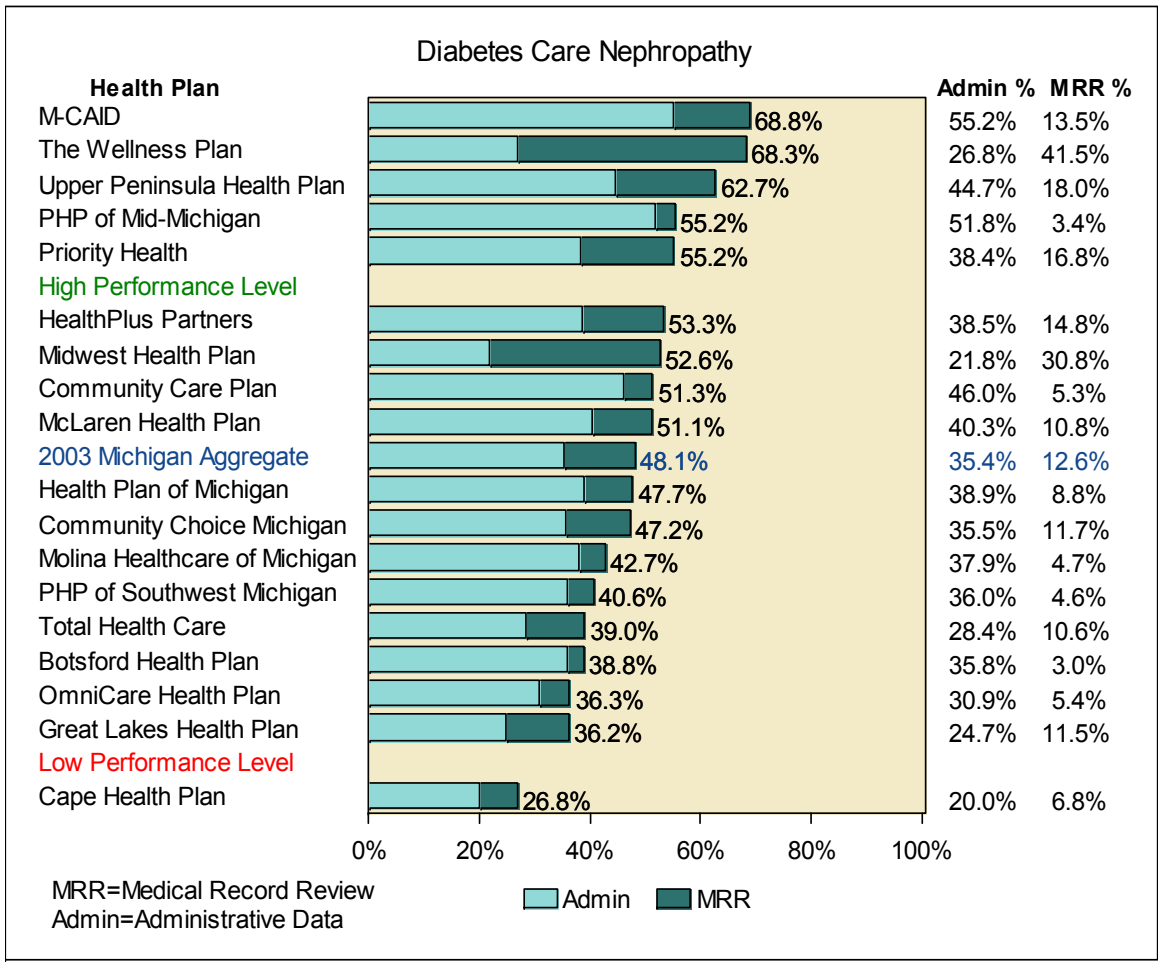


Five of the health plans had reported rates above the HPL, while one health plan (Cape Health Plan) had a rate below the LPL. A total of 12 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 47.6 percent was higher than both the national HEDIS 2002 Medicaid 50th percentile rate of 41.6 percent and just above the 2002 Michigan Medicaid weighted average of 41.0 percent. The Michigan Medicaid weighted average gain in 2003, of 6.6 percentage points, was not statistically significant. The 18 reported rates ranged from 26.8 percent to 68.8 percent. Denominator sizes ranged from 134 to 460.

Data Collection Analysis: Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy

Figure 5-12—Michigan Medicaid HEDIS 2003
Data Collection Analysis:
Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much from the medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2003 Michigan aggregate administrative rate for this measure was 35.4 percent. Overall, 73.6 percent of the aggregate rate was derived from administrative data and 26.4 percent from medical record review. Last year, 64.6 percent of the aggregate rate was derived from administrative data.

The 2003 Michigan aggregate rate increased by 12.6 percentage points by using medical record review. Ten health plans had substantial improvements from medical record review of more than 10 percentage points in their rate, ranging from 10.6 percent to 41.5 percent.

Use of Appropriate Medications for People with Asthma

Asthma accounts for more than 10 million physician visits, 400,000 hospitalizations, 1 million ER visits, and approximately 10 million missed school days annually. It is the most common chronic condition in children and the sixth most common chronic condition overall in the U.S., with 5 million children and 12 million adults affected.[5-17] In 2000, the current asthma prevalence rate reported for adults in Michigan was 7.2 percent of the population, which was the same rate as for the United States population as a whole.[5-18] Management of asthma is critical, and neglect of the condition frequently results in hospitalization, ER visits, and missed work and school days.

HEDIS Specification: Use of Appropriate Medications for People with Asthma

This measure is reported using the administrative method only. In addition to enrollment data, claims are used to identify the denominator. Rates for three age groups: 5 to 9 years, 10 to 17 years, and 18 to 56 years, as well as a combined rate are reported.

Members are identified for each denominator based on age and a criterion of two-year continuous enrollment (the measurement year and the year prior to the measurement year). In addition, this measure requires that members be identified as having *"*persistent asthma.*"* Persistent asthma is defined by HEDIS specifications as having any of the following events within the year prior to the measurement year (in this case, 2000):

- At least four asthma medication-dispensing events; or
- At least one Emergency Department visit with a principal diagnosis of asthma; or
- At least one hospitalization with a principal diagnosis of asthma; or
- At least four outpatient visits with a corresponding diagnosis of asthma and at least two asthma medication-dispensing events.

This measure evaluates whether members with persistent asthma are being prescribed medications acceptable as primary therapy for long-term control of asthma. There are a number of acceptable therapies for people with persistent asthma, although best available evidence demonstrates that inhaled corticosteroids are the preferred primary therapy. For people with moderate to severe asthma, inhaled corticosteroids are the only recommended primary therapy. While long acting beta-agonists are a preferred adjunct therapy for long-term control of moderate to severe asthma, their recommended use is as add-on therapy with inhaled corticosteroids, and therefore should not be included as counting by themselves in this numerator.[5-19]

For this particular measure, NCQA requires that rates be computed using the administrative methodology, so a data collection analysis is not relevant.

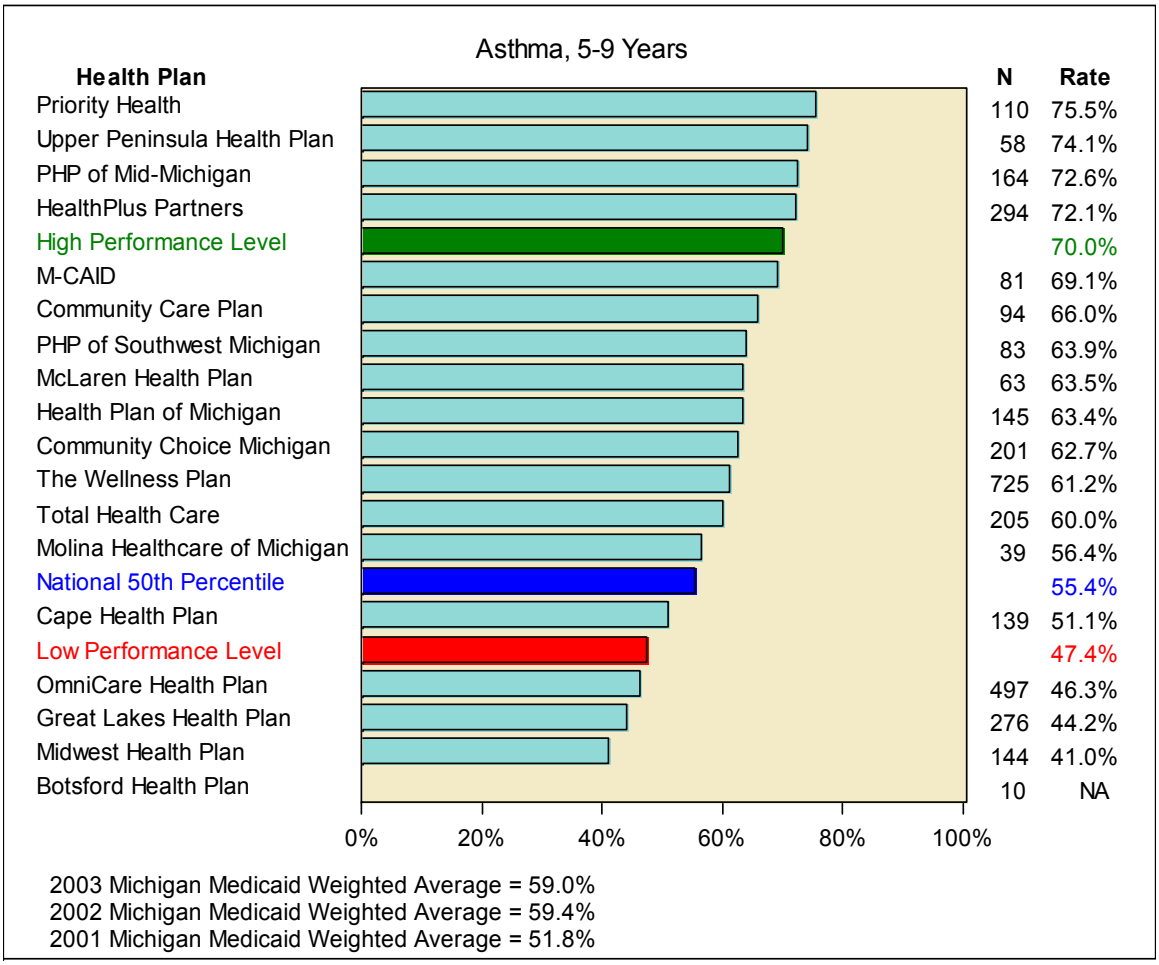
[5-17] National Committee for Quality Assurance. *The State of Managed Care Quality. 2001* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2001:29.

[5-18] American Lung Association of Michigan, Asthma in Adults, 2001. Available at: http://www.getasthmahelp.org/stats_adult.asp. Accessed on October 20, 2003.

[5-19] National Committee for Quality Assurance. *HEDIS 2002 Technical Specifications.* Volume 2. Washington, DC: National Committee for Quality Assurance; 2001:96.

Health Plan Ranking: Use of Appropriate Medications for People with Asthma – Ages 5 to 9 Years

Figure 5-13—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Use of Appropriate Medications for People with Asthma – Ages 5 to 9 Years



Seventeen of the 18 health plans reported a rate for this measure. Four of the health plans had reported rates above the HPL, while three health plans had rates below the LPL. A total of 13 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

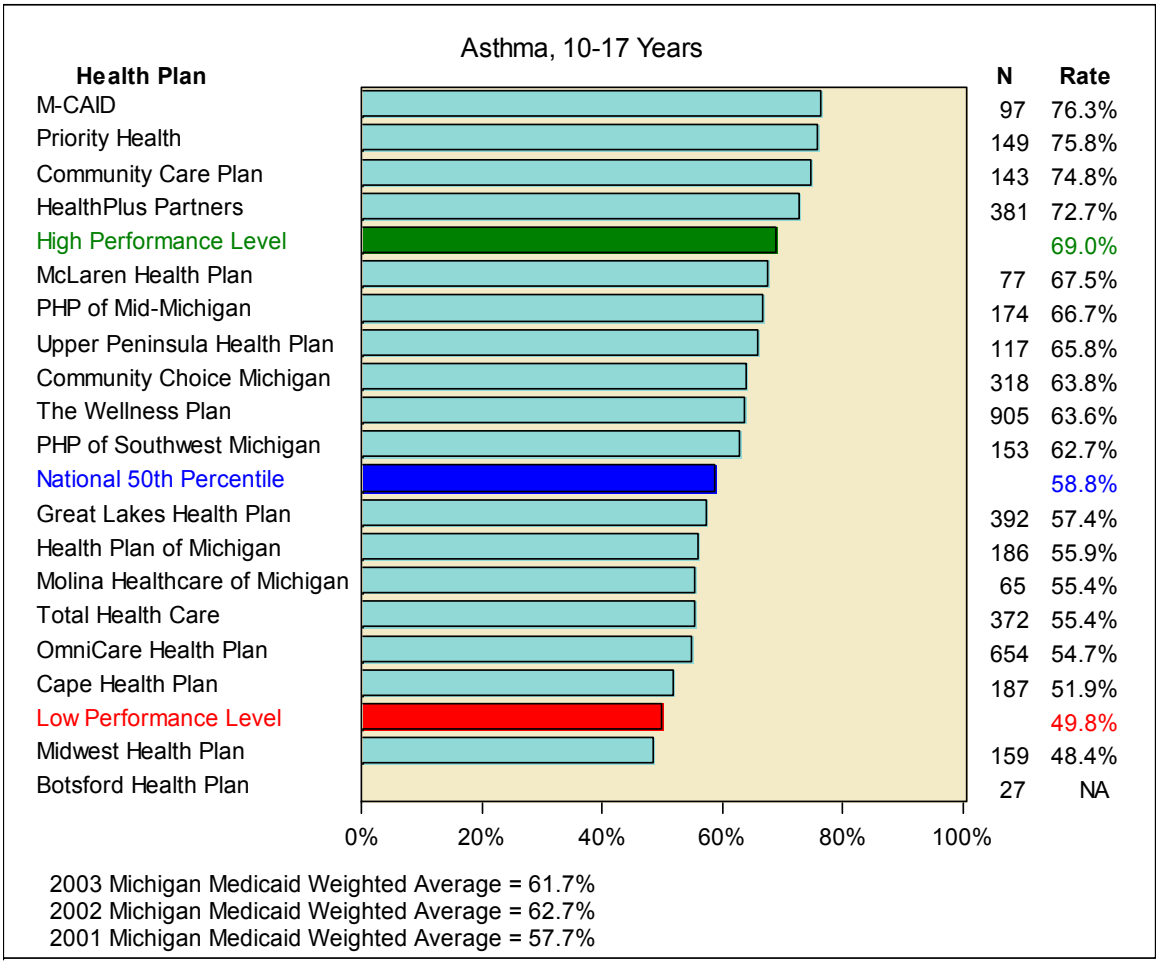
The 2003 Michigan Medicaid weighted average of 59.0 percent was higher than the national HEDIS 2002 Medicaid 50th percentile rate of 55.4 percent, while slightly lower than the 2002 Michigan Medicaid weighted average of 59.4 percent.

The 18 reported rates ranged from 41.0 percent to 75.5 percent. The rate for Botsford Health Plan was designated *Not Applicable* by HEDIS auditors because the sample size was less than 30. Denominator sizes ranged from 10 to 725.

The Michigan Medicaid weighted average decreased in 2003 by 0.4 of a percentage point, which was not statistically significant.

Health Plan Ranking: Use of Appropriate Medications for People with Asthma – Ages 10 to 17 Years

Figure 5-14—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Use of Appropriate Medications for People with Asthma – Ages 10 to 17 Years



Seventeen of the 18 health plans reported a rate for this measure. Four of the health plans had reported rates above the HPL, while one health plan had rates below the LPL. A total of 10 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

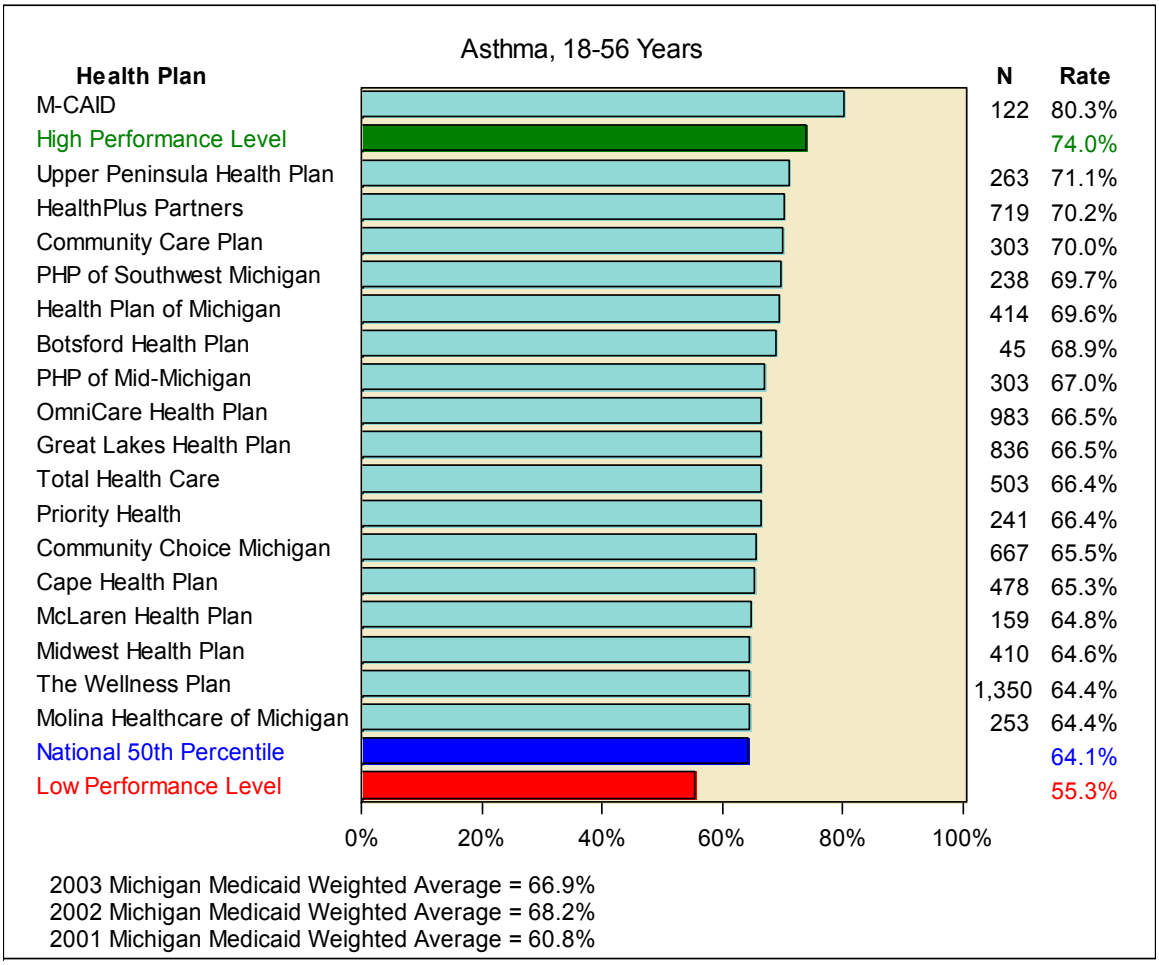
The 2003 Michigan Medicaid weighted average of 61.7 percent was higher than the national HEDIS 2002 Medicaid 50th percentile rate of 58.8 percent, while slightly lower than the 2002 Michigan Medicaid weighted average of 62.7 percent.

The 18 reported rates ranged from 48.4 percent to 76.3 percent. The rate for Botsford Health Plan was designated *Not Applicable* by HEDIS auditors because the sample size was less than 30. Denominator sizes ranged from 27 to 905.

The Michigan Medicaid weighted average decreased in 2003 by 1.0 percentage points, which was not statistically significant.

Health Plan Ranking: Use of Appropriate Medications for People with Asthma – Ages 18 to 56 Years

Figure 5-15—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Use of Appropriate Medications for People with Asthma – Ages 18 to 56 Years

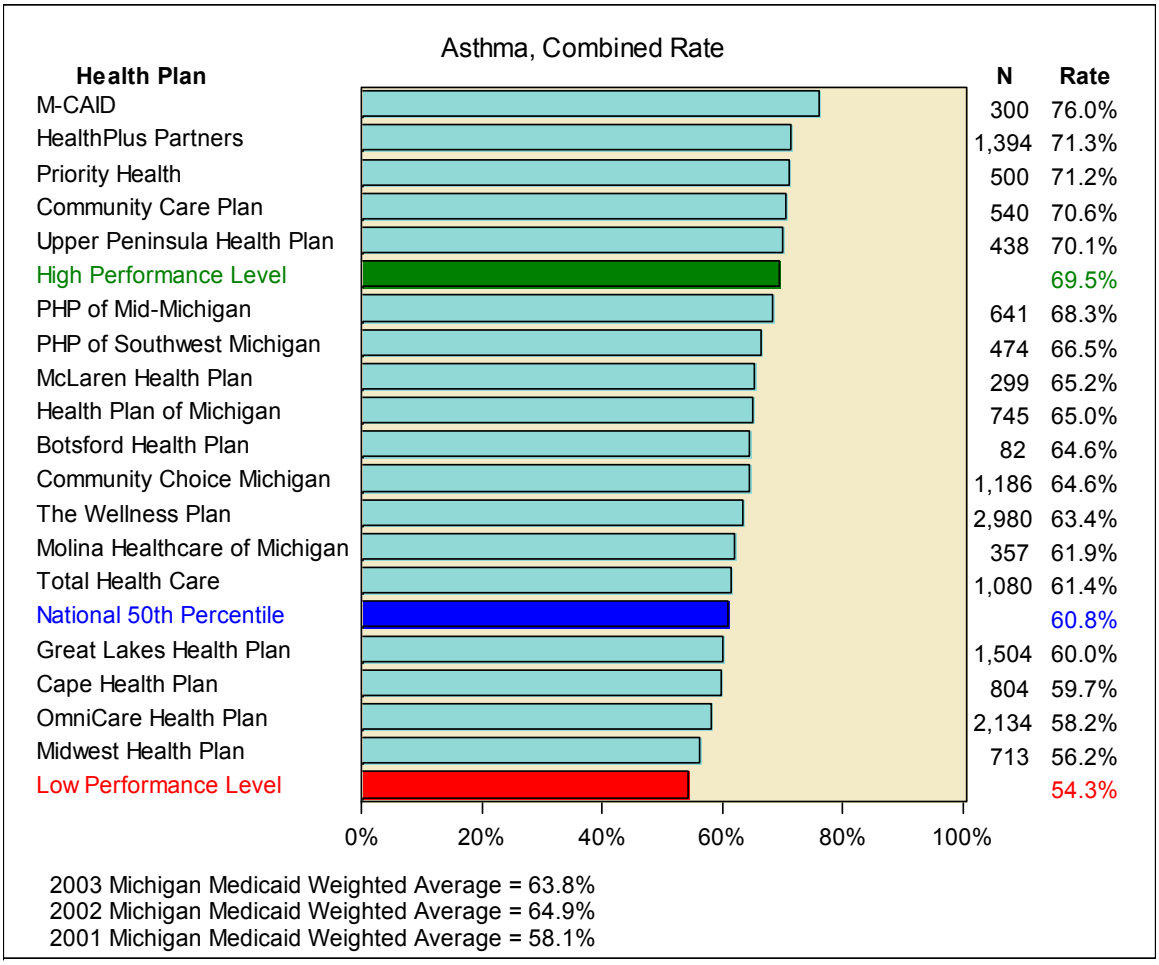


One health plan (M-CAID) had a reported rate above the HPL, while none of the health plans had rates below the LPL. All health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 66.9 percent was higher than the national HEDIS 2002 Medicaid 50th percentile rate of 64.1 percent, while lower than the 2002 Michigan Medicaid weighted average of 68.2 percent. The 18 reported rates ranged from 64.4 percent to 80.3 percent. Denominator sizes ranged from 45 to 1,350. The Michigan Medicaid weighted average decreased in 2003 by 1.3 percentage points, which was not statistically significant.

Health Plan Ranking: Use of Appropriate Medications for People with Asthma – Combined Rate

Figure 5-16—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Use of Appropriate Medications for People with Asthma – Combined Rate



Five of the health plans had reported rates above the HPL, while none of the health plans had rates below the LPL. A total of 14 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 63.8 percent was higher than the national HEDIS 2002 Medicaid 50th percentile rate of 60.8 percent, while lower than the 2002 Michigan Medicaid weighted average of 64.9 percent. The 18 reported rates ranged from 56.2 percent to 76.0 percent. Denominator sizes ranged from 82 to 2,980. The Michigan Medicaid weighted average decreased in 2003 by 1.1 percentage points, which was not statistically significant.

Controlling High Blood Pressure

High blood pressure has long been referred to as the "silent killer" in the medical community. It is a major risk factor for developing cardiovascular disease, stroke, and heart failure. According to the NCQA annual *State of Health Care Quality* report,[5-20] only about 40 percent of the 31 million Americans with diagnosed high blood pressure have their blood pressure adequately controlled. NCQA estimates that an increase to 68 percent nationally, which is already being achieved by top performing health plans, would save an estimated 28,000 lives next year. The Michigan Behavioral Risk Factor Surveillance System[5-21] data from 2001 and 2002 indicate that 21.7 percent of adults in Michigan have high blood pressure. In Michigan, diseases of the heart, including high blood pressure, were the most common cause of death in 2000, responsible for 32 percent of all deaths.[5-22]

HEDIS Specification: Controlling High Blood Pressure

The *Controlling High Blood Pressure* measure assesses if blood pressure was controlled for adults with diagnosed hypertension. This measure calculates the percentage of members aged 46 – 85 years who were continuously enrolled for the measurement year, had a ambulatory claim or encounter with a diagnosis of hypertension which was confirmed within the medical record, and for whom blood pressure was controlled at 140/90 mm Hg or less.

Since this measure must be calculated by using the hybrid methodology only, a data collection analysis is not relevant.

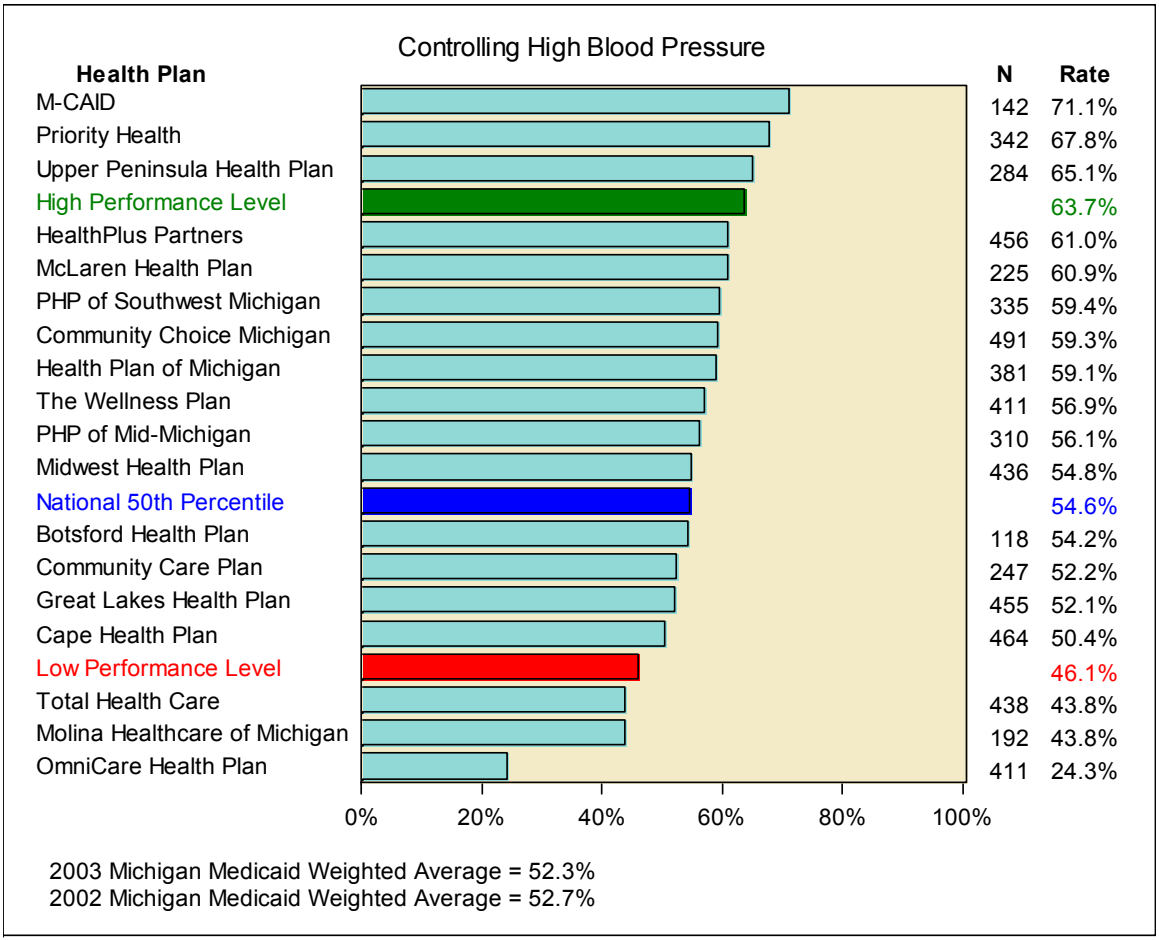
[5-20] National Committee for Quality Assurance News Release, "New Report Finds Health Care System's 'Quality Gaps' Cause 57,000 Deaths Annually." Available at: http://www.ncqa.org/Communications/News/sohc2003.htm. Accessed on October 6, 2003.

[5-21] Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS). Available at: http://www.cdc.gov/brfss/. Accessed on September 8, 2003.

[5-22] Hogan J.G. Epidemiology of Diseases of the Heart. Fact Sheet. Bureau of Epidemiology, Michigan Department of Community Health; December 2002.

Health Plan Ranking: Controlling High Blood Pressure

Figure 5-17—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Controlling High Blood Pressure



Three of the health plans had reported rates above the HPL, while three health plans had rates below the LPL. A total of 11 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 52.3 percent was lower than the national HEDIS 2002 Medicaid 50th percentile rate of 54.6 percent, and slightly lower than the 2002 Michigan Medicaid weighted average of 52.7 percent. The 18 reported rates ranged from 24.3 percent to 71.1 percent. Denominator sizes ranged from 118 to 491. The Michigan Medicaid weighted average decreased in 2003 by 0.4 percentage points, which was not statistically significant.

Medical Assistance with Smoking Cessation – Advising Smokers to Quit

Michigan currently has the sixth highest rate of adult smokers in the nation. State rates have remained relatively consistent since 1992, with the most recent data showing 27.5 percent of adults smoking in 1998 and 26 percent in 2001.[5-23] However, rates are higher for some vulnerable populations: 43 percent of women enrolled in the Michigan Women, Infants, and Children's (WIC) program smoked prior to pregnancy and 30 percent smoked during pregnancy.[5-24] Smoking during pregnancy increases the risk of infant mortality and low birth weight. Children of smokers experience higher rates of asthma than non-smokers.

MDCH has many ongoing efforts to decrease the use of tobacco, including offering free self-help smoking cessation kits, implementing a statewide task force to assist with regulations and ordinances aimed at clean indoor air and smoke-free businesses, smoking cessation programs for pregnant women, counseling for WIC enrollees on the dangers of smoking and second-hand smoke, college initiatives, community education programs, and support of activities related to the Youth Tobacco Act.

Many smokers have been unable to quit even when they know the negative health effects, and know that eliminating tobacco is the single most important step they can take to improve their health. Seven different studies involving brief physician advice to quit (less than three minutes) were analyzed, with results showing that 2.3 percent more patients quit after this minimal intervention than patients with no intervention.[5-25] This shows that even a brief message that is clear, strong, and personalized can have a positive effect on future smoking behavior.

HEDIS Specification – Advising Smokers to Quit

The *Medical Assistance with Smoking Cessation* measure is collected using the CAHPS® survey. *Advising Smokers to Quit* is one component (or rate) reported for the measure. *Advising Smokers to Quit* calculates the percentage of members aged 18 years or older who were continuously enrolled during the measurement year, who were either smokers or recent quitters, who were seen by a health plan practitioner during the measurement year, and who received advice to quit smoking.

The methodology to calculate the rate for *Advising Smokers to Quit* changed. The measure is now calculated using a rolling average. Rates are reported using data from the most recent two reporting years, with the rolling average of 2002 and 2003 included in this report.

Since this measure must be collected using the CAHPS® survey methodology, a data collection analysis is not included.

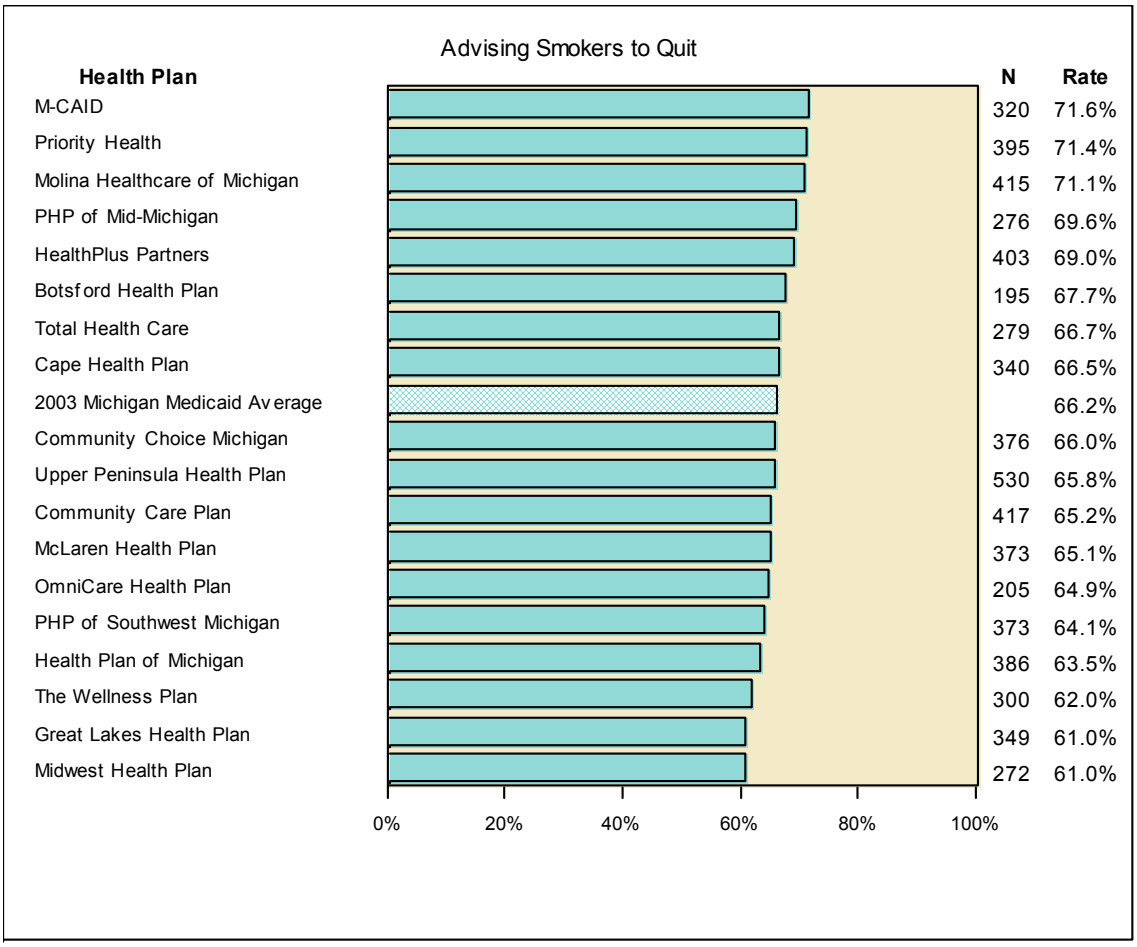
[5-23] Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS). Available at: http://www.cdc.gov/brfss/. Accessed on September 8, 2003.

[5-24] Michigan Department of Community Health Web site. Available at: http://www.michigan.gov/mdch. Accessed on September 5, 2003.

[5-25] Smith SS, Fiore MC. The Epidemiology of Tobacco Use, Dependence, and Cessation in the United States. *Primary Care, Clinics in Office Practice*; September 1999; 26(3):433-61.

Health Plan Ranking: Medical Assistance with Smoking Cessation – Advising Smokers to Quit

Figure 5-18—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Medical Assistance with Smoking Cessation – Advising Smokers to Quit



The cross-hatch bar shows the 2003 Michigan Medicaid Average. This is not a weighted average. Since eligible population data were not available, a weighted average could not be calculated for this measure.

For this measure, 8 of the 18 health plans had rates above the 2003 Michigan Medicaid Average of 66.2 percent. The 18 health plan-reported rates ranged from 61.0 percent to 71.6 percent. Denominator sizes ranged from 195 to 530.

Living with Illness Findings and Recommendations

The key findings indicate that:

- Overall, the rates for all the measures reported in the Living with Illness dimension nearly met, or exceeded, the national averages for Medicaid. None of the Michigan Medicaid weighted averages are above the 75th percentile or below the 25th percentile.
- Most rates for *Comprehensive Diabetes Care* have improved significantly since 2001.
- For *Comprehensive Diabetes Care*, results demonstrate that few health plans have the ability to capture actual laboratory values administratively and/or that laboratory vendors do not regularly provide this level of detailed information.
- The Michigan Medicaid weighted averages for *Use of Appropriate Medications for People with Asthma* and *Controlling High Blood Pressure* have not improved significantly over time.

The 2003 Michigan Medicaid weighted average was identical to the national HEDIS 2002 Medicaid 50th percentile rate for *Comprehensive Diabetes Care – HbA1c Testing*. This measure has improved 13.7 percentage points since 2001. Overall, 89.1 percent of the rate for this measure was derived from administrative data.

For *Comprehensive Diabetes Care – Poor Control,* the 2003 Michigan Medicaid weighted average was just under the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 11.4 percentage points since 2001. Overall, just 23.6 percent of the rate for this measure was derived solely from administrative data, since lab values are required to determine numerator compliance.

The 2003 Michigan Medicaid weighted average for *Comprehensive Diabetes Care — Eye Exam* was 2.1 percentage points below the national HEDIS 2002 Medicaid 50th percentile. This measure has not shown a significant improvement since 2001. Overall, 73.2 percent of the rate for this measure was derived from administrative data.

The 2003 Michigan Medicaid weighted average for *Comprehensive Diabetes Care — LDL-C Screening* was 0.7 percentage points above the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 19.1 percentage points since 2001. Overall, 65.6 percent of the rate for this measure was derived from administrative data.

For *Comprehensive Diabetes Care – LDL-C Level,* the 2003 Michigan Medicaid weighted average was 5.8 percentage points above the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 19.3 percentage points since 2001. Overall, 24.9 percent of the rate for this measure was derived from administrative data, due to the need for actual lab values to identify numerator compliance.

The 2003 Michigan Medicaid weighted average for *Comprehensive Diabetes Care — Monitoring for Diabetic Nephropathy* was 6.0 percentage points above the national HEDIS 2002 Medicaid 50th percentile. This measure has improved 14.8 percentage points since 2001. Overall, 73.6 percent of the rate for this measure was derived from administrative data.

For *Use of Appropriate Medications for People with Asthma – Combined Rate* (all age groups), the 2003 Michigan Medicaid weighted average was 3.0 percentage points above the national HEDIS 2002 Medicaid 50th percentile. This measure has not shown a significant improvement since 2001.

Medical record review is not allowed for this measure, so analysis of the percentage of the rate derived from administrative data are not presented.

This was only the second year the Michigan Medicaid health plans reported on *Controlling High Blood Pressure*. The 2003 Michigan Medicaid weighted average was 2.3 percentage points below the national HEDIS 2002 Medicaid 50th percentile, and nearly identical to the Michigan Medicaid weighted average in 2002. Numerator events are derived solely from medical record review, so analysis of the percentage of the rate derived from administrative data are not applicable.

Improving the rates for the HEDIS measures in this dimension may require more intense case management at the health plan level, along with provider incentives and education. Medicaid health plans in other states that have shown significant improvement in these measures used case management along with automated reports. For example, reports were sent to high volume providers each month showing rates for various HEDIS indicators for diabetes. A case management nurse in charge of the process then met with the low performing providers on a quarterly basis. Financial incentives were given to providers for completing tests on diabetic members and for showing improvement in outcomes, such as lower HbA1c levels, in these members. Using these strategies, rates above the 90th percentiles were achieved.

Health plans that work directly with their lab vendors to receive lab data have also seen improvement in their rates for the *Comprehensive Diabetes Care - Poor HbA1c Control* and *LDL-C Level* measures. An added benefit of decreasing the reliance on medical record review allows the health plans to focus resources on other areas, such as provider education or focused case management activities.

Proactive HEDIS measure review (i.e., identifying members who meet denominator criteria, but do not have the services provided) during the measurement year can be useful to target specific individuals and also improve rates.

Additionally, the State of Michigan developed and implemented the Michigan Asthma Strategic Plan. Current activities address quality improvement in asthma care, asthma tracking, and environmental quality. The rates for *Use of Appropriate Medications for People with Asthma* are expected to improve as the quality improvement efforts in this area mature.

Introduction

Access to care is the foundation for diagnosing and treating health problems as well as for increasing the quality and years of healthy life. Establishing a relationship with a Primary Care Provider is essential to improving access to care for both adults and children. The public health system, health plans, and health care researchers focus on identifying barriers to the use of existing health services and eliminating disparities in order to increase access to quality care. By breaking down barriers to care and improving access, health plans can increase preventive care and successful management of disease processes.

The following pages provide detailed analysis of Michigan Medicaid health plan performance and ranking. For all measures in this dimension HEDIS methodology requires that the rates be derived using only the administrative method. Medical record review is not permitted, and therefore a data collection analysis is not relevant.

The Access to Care dimension encompasses the following MDCH Key Measures:

- **Children's Access to Primary Care Practitioners**
  - *Children's Access to Primary Care Practitioners – Ages 12 to 24 Months*
  - *Children's Access to Primary Care Practitioners – Ages 25 Months to 6 Years*
  - *Children's Access to Primary Care Practitioners – Ages 7 to 11 Years*

- **Adults' Access to Preventive/Ambulatory Health Services**
  - *Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years*
  - *Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years*
  - *Adults' Access to Preventive/Ambulatory Health Services – Ages 65+*

Children's Access to Primary Care Practitioners

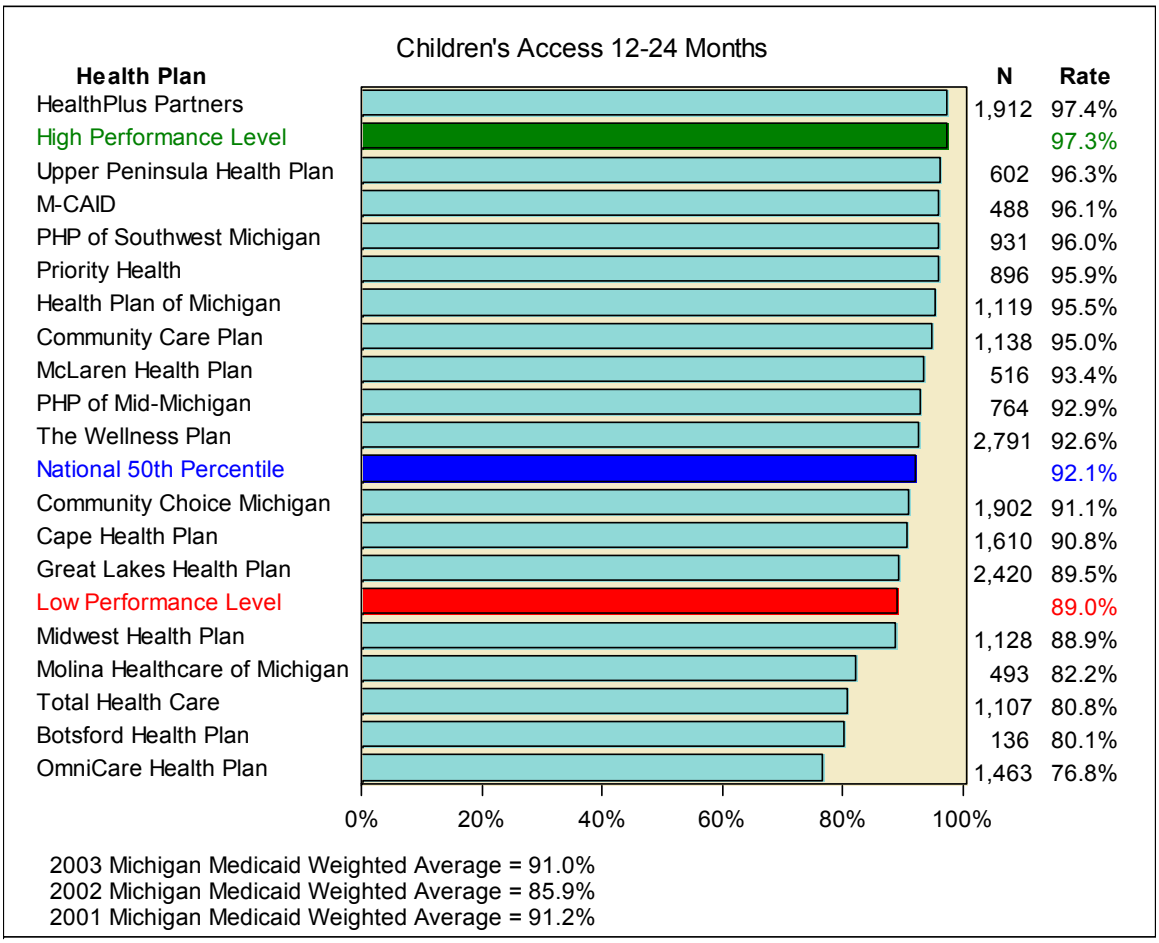
The *Children's Access to Primary Care Practitioners* measure looks at visits to pediatricians, family physicians, and other primary care providers as a way to assess general access to care for children. Rates for three age groups are provided: Ages 12 to 24 months, 25 months to 6 years, and 7 to 11 years.

HEDIS Specification: Children's Access to Primary Care Practitioners—Ages 12 to 24 Months

Children's Access to Primary Care Practitioners—Ages 12 to 24 Months calculates the percentage of members aged 12 months through 24 months who were continuously enrolled during the measurement year, and who had a visit with a health plan primary care practitioner during the measurement year.

Health Plan Ranking: Children's Access to Primary Care Practitioners—Ages 12 to 24 Months

Figure 6-1—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Children's Access to Primary Care Practitioners—Ages 12 to 24 Months



One health plan reported a rate above the HPL of 97.3 percent, while five health plans had rates below the LPL of 89.0 percent. A total of 10 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile. Only one health plan had a rate below 80 percent.

The 2003 Michigan Medicaid weighted average of 91.0 percent was 1.1 percentage points below the national HEDIS 2002 Medicaid 50th percentile of 92.1 percent. The reported rates ranged from a low of 76.8 percent to a high of 97.4 percent.

The 2003 Michigan Medicaid weighted average was 5.1 percentage points higher than in 2002, and nearly identical to the 2001 Michigan Medicaid weighted average of 91.2 percent.

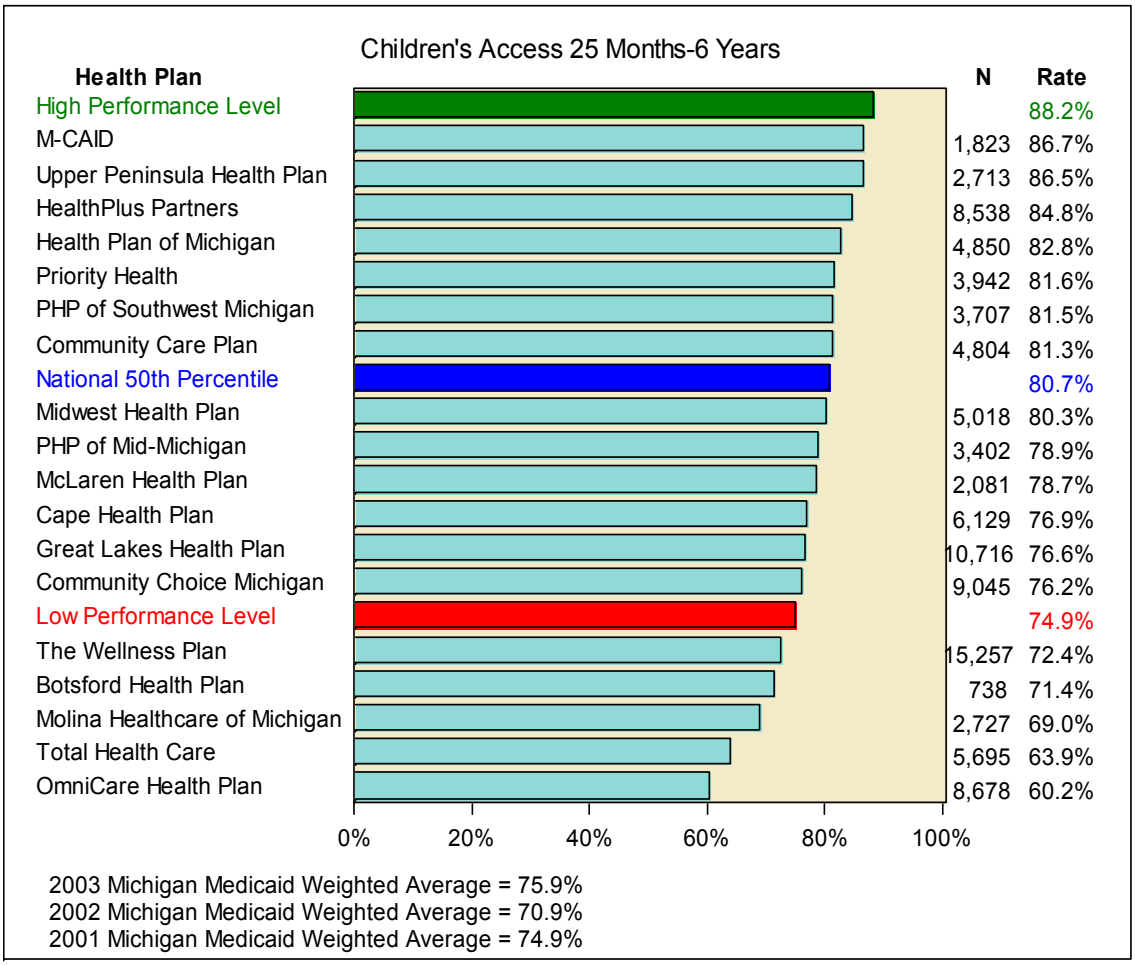
In 2002, three health plans reported rates above the HPL and three had rates below the LPL. Although there were fewer health plans with rates above the HPL and more below the LPL this year, overall average increased and the range of rates among the health plans decreased.

HEDIS Specification: Children's Access to Primary Care Practitioners—Ages 25 Months to 6 Years

Children's Access to Primary Care Practitioners—Ages 25 Months to 6 Years reports the percentage of members aged 25 months through 6 years who were continuously enrolled during the measurement year, and who had a visit with a health plan primary care practitioner during the measurement year.

Health Plan Ranking: Children's Access to Primary Care Practitioners—Ages 25 Months to 6 Years

Figure 6-2—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Children's Access to Primary Care Practitioners—Ages 25 Months to 6 Years



None of the health plans reported a rate above the HPL of 88.2 percent, while five health plans had rates below the LPL of 74.9 percent. A total of seven health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 75.9 percent was 4.8 percentage points below the national HEDIS 2002 Medicaid 50th percentile of 80.7 percent and just 1.0 percentage point above the LPL. The reported rates ranged from a low of 60.2 percent to a high of 86.7 percent.

The 2003 Michigan Medicaid weighted average was 5.0 percentage points higher than in 2002, and 1.0 percentage point higher than the 2001 Michigan Medicaid weighted average of 74.9 percent.

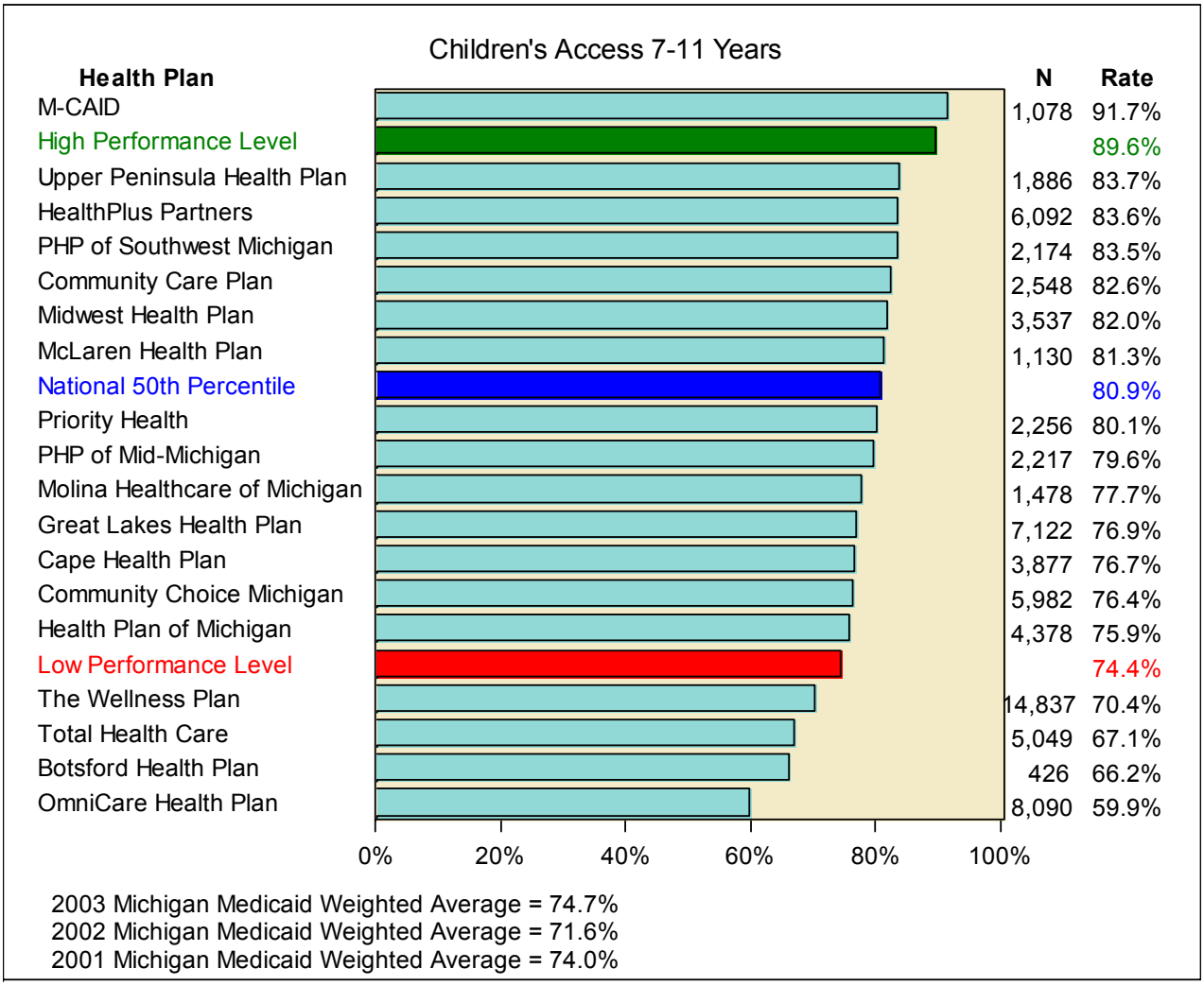
In 2002, none of the health plans reported rates above the HPL, and four had rates below the LPL. The results for 2003 had a total of five health plans below the LPL, but the weighted average was 1.0 percentage point higher than the LPL and the range of rates among the health plans was considerable smaller. Although the overall rates are not optimal, the results continue to show improvement over time.

HEDIS Specification: Children's Access to Primary Care Practitioners—Ages 7 to 11 Years

Children's Access to Primary Care Practitioners—Ages 7 to 11 Years reports the percentage of members aged 7 years through 11 years who were continuously enrolled during the measurement year, and who had a visit with a health plan primary care practitioner during the measurement year or the year prior to the measurement year.

Health Plan Ranking: Children's Access to Primary Care Practitioners—Ages 7 to 11 Years

Figure 6-3—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Children's Access to Primary Care Practitioners—Ages 7 to 11 Years



One health plan reported a rate above the HPL of 89.6 percent, while four health plans had rates below the LPL of 74.4 percent. A total of seven health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 74.7 percent was 6.2 percentage points below the national HEDIS 2002 Medicaid 50th percentile of 80.9 percent. The reported rates ranged from a low of 59.9 percent to a high of 91.7 percent.

The 2003 Michigan Medicaid weighted average was 3.1 percentage points higher than in 2002, and 0.7 of a percentage point higher than the 2001 Michigan Medicaid weighted average.

The same number of health plans had rates above the HPL and below the LPL in 2002 and 2003. Trends for this measure have not shown any significant improvement in the rates.

Adults' Access to Preventive/Ambulatory Health Services

The majority of adults have relatively frequent contact with their health care providers. According to the NCQA,[6-1] 85 percent of Americans reported at least one visit with their health care provider within the last year, and 13.5 percent reported 10 or more visits.

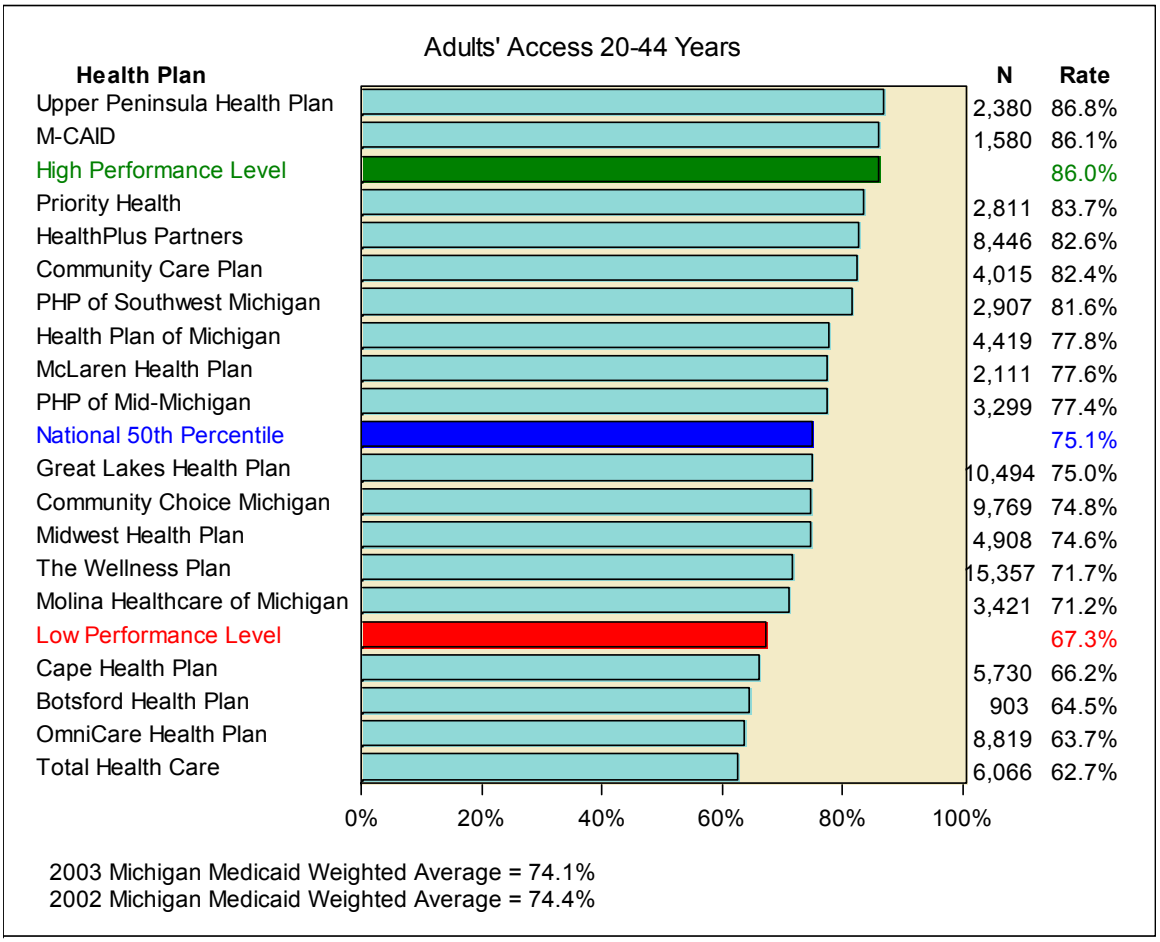
HEDIS Specification: Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years

The *Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years* measure calculates the percentage of adults aged 20 – 44 years who were continuously enrolled during the measurement year, and who had an ambulatory or preventive care visit during the measurement year.

[6-1] National Committee for Quality Assurance (NCQA). The State of Managed Care Quality, 2001. Available at: http://www.ncqa.org/somc2001/intro/somc_2001_industry.htm. Accessed on September 8, 2003.

Health Plan Ranking: Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years

Figure 6-4—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years



Two health plans reported rates above the HPL of 86.0 percent, while four health plans had rates below the LPL of 67.3 percent. A total of nine health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 74.1 percent was 1.0 percentage point below the national HEDIS 2002 Medicaid 50th percentile of 75.1 percent. The reported rates ranged from a low of 62.7 percent to a high of 86.8 percent.

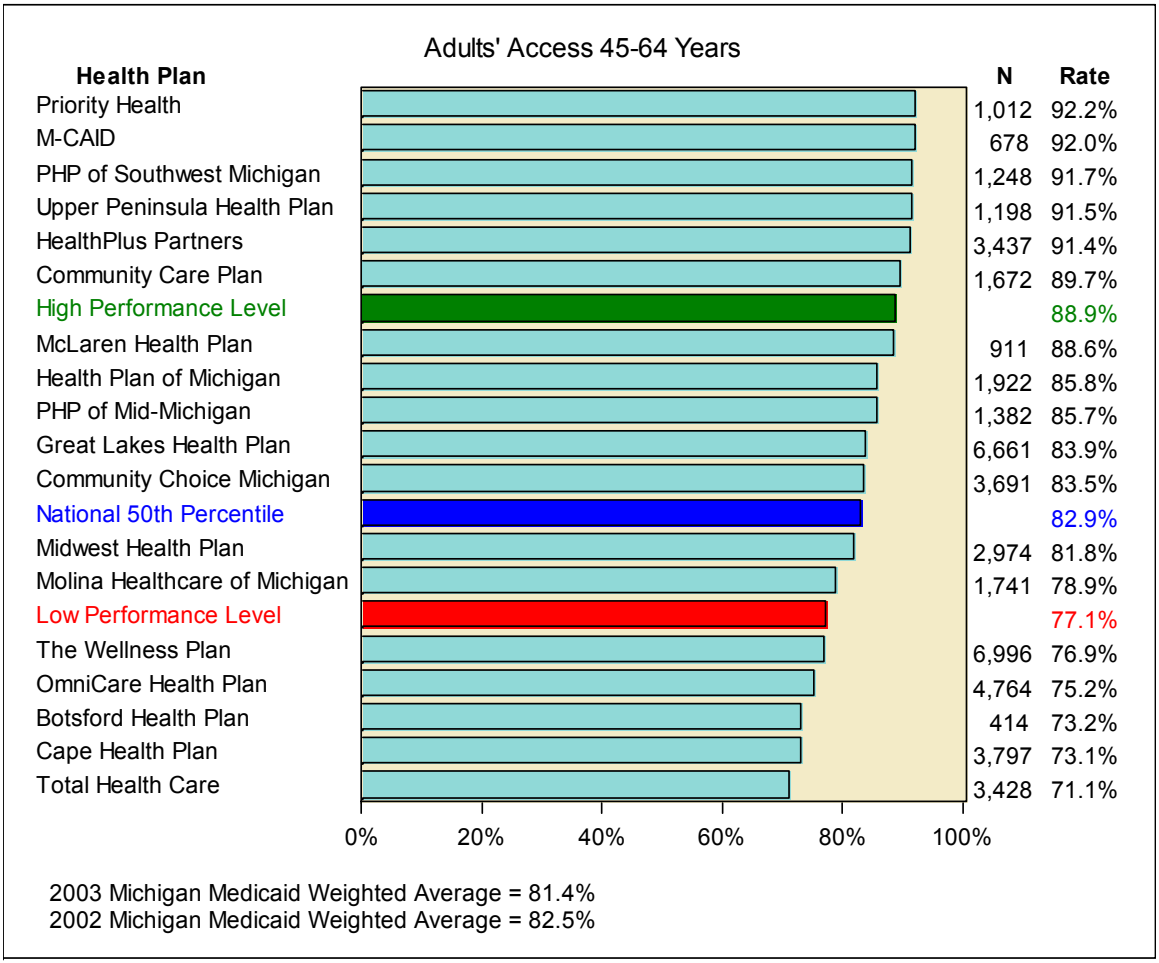
The 2003 Michigan Medicaid weighted average was only 0.3 of a percentage point lower than the 2002 Michigan Medicaid weighted average. This measure was used as a "tracking measure" in 2002 and results by individual health plans were not ranked. In addition, results for 2001 were not available. Therefore, trending the results was limited to just the 2002 and 2003 aggregate results.

HEDIS Specification: Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years

The *Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years* measure calculates the percentage of adults aged 45 – 64 years who were continuously enrolled during the measurement year, and who had an ambulatory or preventive care visit during the measurement year.

Health Plan Ranking: Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years

Figure 6-5—Michigan Medicaid HEDIS 2003
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years



Six health plans reported rates above the HPL of 88.9 percent, and five of those six health plans had rates above 90 percent. Five health plans had rates below the LPL of 77.1 percent. A total of 11 health plans reported rates above the national HEDIS 2002 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 81.4 percent was 1.5 percentage points below the national HEDIS 2002 Medicaid 50th percentile of 82.9 percent. The reported rates ranged from a low of 71.1 percent to a high of 92.2 percent.

The 2003 Michigan Medicaid weighted average was only 1.1 percentage points lower than the 2002 Michigan Medicaid weighted average. This measure was used as a "tracking measure" in 2002 and results by individual health plans were not ranked. In addition, results for 2001 were not available. Therefore, trending the results was limited to just the 2002 and 2003 aggregate results.

HEDIS Specification:Adults' Access to Preventive/Ambulatory Health Services – Ages 65+

The *Adults' Access to Preventive/Ambulatory Health Services – Ages 65+* measure calculates the percentage of adults aged 65 years and older who were continuously enrolled during the measurement year, and who had an ambulatory or preventive care visit during the measurement year.

For this Key Measure, 17 of the 18 health plans had a Not Applicable (NA) audit designation; therefore, no ranking graph was created.

Access to Care Findings and Recommendations

The key findings indicate that:

- 2003 rates for all age groups have not shown significant improvement when compared to 2002.
- All age groups are below the national HEDIS 2002 Medicaid 50th percentile.

For *Children's Access to Primary Care Practitioners – Ages 12 to 24 Months*, the 2003 Michigan Medicaid weighted average was 1.1 percentage points below the national HEDIS 2002 Medicaid 50th percentile. This rate has improved by 5.1 percentage points since 2002. However, compared to 2001, the rate has slightly decreased.

The 2003 Michigan Medicaid weighted average for *Children's Access to Primary Care Practitioners – Ages 25 Months to 6 Years* was 4.8 percentage points below the national HEDIS 2002 Medicaid 50th percentile. The rate has improved by 5 percentage points since 2002 but only 1 percentage point since 2001.

For *Children's Access to Primary Care Practitioners – Ages 7 to 11 Years*, the 2003 Michigan Medicaid weighted average was 6.2 percentage points below the national HEDIS 2002 Medicaid 50th percentile. The rate has improved by 3.1 percentage points since 2002, and by 0.7 of a percentage point since 2001.

The 2003 Michigan Medicaid weighted average for *Adults' Access to Preventive/Ambulatory Health Services – Ages 20 to 44 Years* was 1.0 percentage point below the national HEDIS 2002 Medicaid 50th percentile.

For *Adults' Access to Preventive/Ambulatory Health Services – Ages 45 to 64 Years,* the 2003 Michigan Medicaid weighted average was 1.5 percentage points below the national HEDIS 2002 Medicaid 50th percentile. The rate declined 1.1 percentage points in comparison to 2002. There were six health plans above the HPL for this measure, the most out of all six age bands.

Seventeen out of 18 health plans had a Not Applicable (NA) for the *Adults' Access to Preventive/Ambulatory Health Services – Ages 65+* measure, which means the sample size was less than 30. Therefore, comparisons will not be made on this measure.

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States. Improving access to care requires addressing many barriers, including those that involve the patient, provider, and system of care.[6-2]

Patient barriers include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive care. Health provider barriers include limited time, lack of training in prevention, lack of perceived effectiveness of selected preventive services, and practice environments that fail to facilitate prevention. Computerized or manual tracking systems, patient and clinician reminders, clinical guidelines, and patient information materials can help providers improve delivery of necessary preventive care.[6-3] System barriers can include lack of resources or attention devoted to prevention, lack of coverage or inadequate reimbursement for services, and lack of systems to track the quality of care. Systems interventions that can increase delivery of health care include offering clinical preventive services

[6-2] Agency for Healthcare Research and Quality. *Healthy People 2010: Access to Quality Health Services.* Available at: http://www.healthypeople.gov/document/html/volume1/01access.htm. Accessed on September 8, 2003.
[6-3] Ibid.

among standard covered benefits, providing feedback on performance to providers and practices, offering incentives for improved performance, and developing, and implementing systems to identify and provide outreach to individuals in need of services.[6-4]

HSAG recommends health plans incorporate patient, provider, and system interventions as mentioned above for all Access to Care measures.

[6-4] Agency for Healthcare Research and Quality. *Healthy People 2010: Access to Quality Health Services.* Available at: http://www.healthypeople.gov/document/html/volume1/01access.htm. Accessed on September 8, 2003.

Introduction

When examining the HEDIS rates listed in this report and making comparisons among the health plans, across the State, and to national percentiles, it is important to keep in mind the data collection and reporting issues that the Michigan Medicaid health plans face. These issues and their potential impact on a given rate are discussed in this section of the report.

Common Audit Issues for 2003

From the review of each health plan's Final Audit Reports and Data Submission Tools (DSTs), HSAG has compiled a list of audit issues that commonly occur among Michigan Medicaid health plans. These audit issues are described below.

Inaccurate Claims/Encounter Data Capture

Six of the 18 health plans were identified as having performed inaccurate claims/encounter data capture; however, none resulted in a *Not Report* audit designation for any Key Measure.

> IS Standard 2.2 requires that claims/encounter data entry processes must be timely, efficient, and accurate. Health plans are expected to oversee and monitor data entry activities to ensure that data accuracy meets established standards.

Six Michigan Medicaid health plans were identified as not meeting the standard, due to inaccurate coding of ER visits or urgent care visits at the provider level or at the data entry level. In all circumstances, the health plans implemented workarounds in order to report accurately all HEDIS measures. While there was no impact on the final reported rates due to this issue, health plans invested time and resources to rectify the inaccurate codes.

Encounter Data Completeness

This issue has been ongoing from the 2001 audit. Four of the 18 health plans were affected; however, none received a *Not Report* audit designation for any Key Measure related to this issue.

> IS Standard 2.5 requires that health plans monitor data completeness and takes steps to improve performance.

Health plans that have capitated reimbursement arrangements with providers commonly identify encounter data completeness as an issue. This issue affects a health plan's ability to report any rates administratively, and forces the health plan to rely heavily on medical record review to report hybrid measures. This standard is composed of two areas of focus. First, health plans were evaluated by the auditors in terms of their efforts to identify and quantify data completeness issues (by monitoring provider submission patterns, trending volumes of encounter data submitted over time, and comparing administrative data results to medical record review findings, etc.). Secondly, health plan efforts to improve data completeness (such as the implementation of incentive programs, provider profiling, and provider education) were also evaluated.

The auditors determined that four health plans did not meet the data completeness standard (IS 2.5); however, none received a *Not Report* audit designation related to this issue.

Provider Data

This issue has been ongoing from the 2001 audit. Three of the 18 health plans were affected; however, none received a *Not Report* audit designation for any Key Measure related to this issue.

Three Michigan Medicaid health plans were cited as being non-compliant with the provider-related IS Standards. Issues with provider data collection included a lack of data entry oversight, lack of automated edit checks, incomplete or inaccurate provider data maintained on multiple databases, and the inability to capture multiple board certifications for providers who practice in more than one specialty. Such practices can cause a health plan to be out of compliance with NCQA Standards for provider data and can result in a *Not Report* audit designation for provider-related HEDIS measures. These issues, however, had no impact on the Key Measures.

Overall Improvements Since the 2002 Audit

Overall, Michigan Medicaid health plans have made significant improvements to their HEDIS data collection and reporting processes. Many improvements suggested by auditors have been acted upon successfully, resulting in increased compliance with IS Standards and more efficient HEDIS reporting. The following improvements in the processes for data collection and reporting were identified during the HEDIS 2003 audit:

- **Health Plans Improved Data Completeness.**

Most of the Michigan Medicaid health plans conducted data completeness studies and took necessary actions to improve performance. Many implemented incentives for data submission and provided feedback to providers on submission volumes. In addition, the auditors noted that encounter data submission had significantly improved for several health plans.

- **Increased Use of Certified Software/Software Vendors.**

Twelve of the 18 Michigan Medicaid health plans either contracted with NCQA-certified vendors or used certified software to generate their HEDIS measures. Certified software vendors can bring to the health plan expertise in accurate and efficient reporting of HEDIS data. In addition, the health plan does not need to focus resources on source code development and testing; rather, the health plan can concentrate on the generated rates to ensure they are accurate.

- **Provider Data Collection Practices Improved.**

Although health plans continued to face difficulties with provider data collection and remained non-compliant with provider-related IS Standards, many Michigan Medicaid health plans took steps to improve their provider data collection practices. Some contracted with vendors for the necessary data collection, while others collecting data in multiple databases routinely reconciled the data to assure their accuracy.

- **Medical Record Review Practices Improved.**

Auditors noted many improvements in the area of manual data collection (medical record review). Health plans were found to have the appropriate levels of training and monitoring for abstractors, were able to locate the necessary records in a timely fashion, and performed abstraction efficiently and accurately. Several health plans switched from the use of paper abstraction tools to automated

electronic tools, which have more built-in edits and quality-checking capabilities. In addition, every Michigan Medicaid health plan passed the auditor's medical record validation of two selected measures.

Recommendations for the Michigan Department of Community Health

The Michigan Medicaid health plans have gained experience through years of reporting HEDIS data and have implemented more efficient practices and sound processes that are evident in the HEDIS Compliance Audit reports. It may be beneficial for MDCH to establish a forum for the health plans to share some lessons learned and best practices in the area of HEDIS data collection and reporting. Some states have collaborated with NCQA to provide a HEDIS training session, specifically targeted to the reporting needs of their state. The MDCH should attempt to maintain a relatively consistent set of Key Measures, and carefully consider the data sources and data collection needs when adding new measures to the required reporting set. When considering first-year measures, HSAG recommends that the MDCH consult with the health plans on the capability to collect the necessary data and determine communally whether the measure adds value to the state's overall quality improvement strategy.

Introduction

This section contains these appendices:

- Appendix A: Caveats and Limitations
- Appendix B: Tabular Results for Key Measures by Health Plan
- Appendix C: National HEDIS 2002 Medicaid Percentiles
- Appendix D: Glossary

APPENDIX A. Caveats and Limitations

HEDIS Compliance Audit Final Reports

The HEDIS Compliance Audits were performed by five different licensed audit organizations. Although NCQA requires adherence to a standard methodology for performing HEDIS Compliance Audits, within the on-site methodologies variations were apparent among the audit organizations. This fact could potentially impact the final audit findings and HSAG's ability to compare findings accurately across all the health plans.

Audit Designations

There were limitations in identifying the rationales for *Not Report* audit designations within NCQA's DST. The rationale is the reason indicated by the auditor as to why a *Not Report* audit designation was assigned. The DST does not allow the auditor to assign an audit designation rationale to each individual rate reported in the *Well-Child in the First 15 Months of Life* measure. The measure as a whole is assigned an audit designation with the corresponding rationale. HSAG used the rationale assigned to the measure as a whole for both the *Zero Visits* and *Six or More Visits* rates.

There were some discrepancies noted between the rates reported as *Not Applicable* in the DST and the rationale assigned by the auditor. If a rate is reported as *Not Applicable*, the measure is assigned an audit designation of *Report*, and the rationale assigned is Rationale #2 (the health plan followed the specifications for producing a reportable denominator but the denominator was too small—under 30—to report a valid rate, resulting in a *Not Applicable,* or NA). However, there were circumstances in which a rate was reported as *Not Applicable*, but the rationale assigned by the auditor was Rationale #1 (the health plan followed the specifications and produced a reportable rate for the measure). In these circumstances, HSAG adjusted the rationale to accurately reflect the *Not Applicable* rate.

Interpreting and Using Reported Averages and Aggregate Results

The 2003 Michigan Medicaid Weighted Average was computed by HSAG based on the reported rates and weighted by the reported eligible population size for that measure. This is a better estimate of care for all of Michigan's Medicaid enrollees, rather than the average performance of Michigan Medicaid Health Plans.

The 2003 Michigan Medicaid Aggregate results, which illustrate how much of the final rate is derived from administrative data and how much from medical record review, is not an average. It is the sum of all numerator events divided by the sum of all the denominators across all the reporting health plans for a given measure.

Example

For example, three health plans in a given state reported for a particular measure:

- Health Plan A used the administrative method and had 6,000 numerator events out of 10,000 members in the denominator (60 percent).
- Health Plan B also used the administrative method and found 5,000 numerator events out of 15,000 members (33 percent).
- Health Plan C used the hybrid methodology and had 8,000 numerator events (1,000 of which came from medical record abstraction) and had 16,000 members in the denominator (50 percent).
- There are a total of 41,000 members across plans.
- There are 19,000 numerator events across plans, 18,000 from administrative data and 1,000 from medical record abstraction.
- The rates are as follows:
  - The overall aggregate rate is 46 percent (or 19,000/41,000).
  - The administrative aggregate rate is 44 percent (or 18,000/41,000).
  - The medical review rate is 2 percent (or 1,000/41,000).

APPENDIX B. Tabular Results for Key Measures by Health Plan

This section presents tables showing results for Key Measures by health plan.

Table B-1—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Immunization Status

			Childhood Immunization Status			Adolescent Immunization Status		
DST	Plan Name	Code	Eligible Population	Combo 1 Rate	Combo 2 Rate	Eligible Population	Combo 1 Rate	Combo 2 Rate
4136	Botsford Health Plan	BOT	99	50.5%	49.5%	160	28.1%	10.6%
4333	Cape Health Plan	CAP	1,366	65.3%	60.6%	1,024	39.4%	21.5%
4139	Community Care Plan	CCP	971	76.9%	70.8%	687	50.0%	30.8%
4265	Community Choice Michigan	CCM	2,018	61.8%	58.8%	1,586	29.4%	11.3%
4133	Great Lakes Health Plan	GLH	2,226	68.9%	65.7%	2,037	32.2%	17.4%
4291	Health Plan of Michigan	HPM	909	66.9%	60.9%	686	38.7%	19.4%
4056	HealthPlus Partners	HPP	1,922	77.1%	72.0%	1,411	47.8%	26.2%
4243	M-CAID	MCD	414	78.4%	73.8%	258	51.2%	35.0%
4312	McLaren Health Plan	MCL	390	72.1%	63.1%	332	39.2%	15.4%
4131	Midwest Health Plan	MID	1,004	65.7%	61.1%	923	35.2%	25.2%
4151	Molina Healthcare of Michigan	MOL	440	68.0%	59.1%	530	27.9%	9.4%
4055	OmniCare Health Plan	OCH	1,771	34.1%	31.6%	2,028	20.7%	8.8%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	804	71.5%	67.9%	564	51.1%	15.8%
4283	Physician's Health Plan of Southwest Michigan	PSW	888	75.9%	71.3%	604	46.7%	13.9%
4054	Priority Health Government Programs	PRI	1,044	69.3%	66.2%	608	50.1%	26.5%
4268	Total Health Care	THC	1,181	59.3%	55.3%	1,302	31.9%	19.7%
4348	Upper Peninsula Health Plan	UPP	578	75.9%	58.4%	487	38.9%	11.9%
4218	The Wellness Plan	TWP	3,063	59.9%	56.9%	3,702	48.7%	32.1%
	2003 Michigan Medicaid Weighted Average			64.8%	60.4%		38.5%	20.7%
	2002 Michigan Medicaid Weighted Average			64.7%	58.4%		33.7%	14.8%
	2001 Michigan Medicaid Weighted Average			56.7%	45.6%		24.7%	8.8%
	National HEDIS 2002 Medicaid 50th Percentile			60.7%	53.8%		33.6%	13.0%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

R denotes a *Report* audit designation.
NR denotes a *Not Report* audit designation.
NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-2—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Well-Child Visits in the First 15 Months of Life

DST	Plan Name	Code	Eligible Population	0 Visits Rate	6 or More Visits Rate
4136	Botsford Health Plan	BOT	43	11.6%	51.2%
4333	Cape Health Plan	CAP	559	7.2%	31.7%
4139	Community Care Plan	CCP	632	2.1%	39.6%
4265	Community Choice Michigan	CCM	1,343	6.3%	15.5%
4133	Great Lakes Health Plan	GLH	1,328	7.2%	30.6%
4291	Health Plan of Michigan	HPM	516	2.8%	56.3%
4056	HealthPlus Partners	HPP	1,370	3.5%	43.2%
4243	M-CAID	MCD	238	0.8%	90.3%
4312	McLaren Health Plan	MCL	261	1.9%	52.5%
4131	Midwest Health Plan	MID	585	4.6%	39.8%
4151	Molina Healthcare of Michigan	MOL	158	8.9%	30.4%
4055	OmniCare Health Plan	OCH	983	14.4%	20.0%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	462	2.4%	41.8%
4283	Physician's Health Plan of Southwest Michigan	PSW	603	1.9%	43.6%
4054	Priority Health Government Programs	PRI	667	1.9%	49.1%
4268	Total Health Care	THC	738	10.4%	23.6%
4348	Upper Peninsula Health Plan	UPP	378	0.8%	46.3%
4218	The Wellness Plan	TWP	2,193	1.9%	55.2%

2003 Michigan Medicaid Weighted Average		5.0%	39.2%
2002 Michigan Medicaid Weighted Average		6.5%	35.5%
2001 Michigan Medicaid Weighted Average		11.1%	24.6%
National HEDIS 2002 Medicaid 50th Percentile		4.5%	35.7%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

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NR denotes a *Not Report* audit designation.
NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-3—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits

			3rd–6th Years of Life		Adolescent	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	610	47.2%	1,235	25.3%
4333	Cape Health Plan	CAP	4,133	59.1%	5,455	37.7%
4139	Community Care Plan	CCP	3,786	58.0%	5,125	36.1%
4265	Community Choice Michigan	CCM	7,308	46.3%	10,293	30.6%
4133	Great Lakes Health Plan	GLH	8,562	56.9%	13,332	36.1%
4291	Health Plan of Michigan	HPM	3,871	58.8%	5,220	31.3%
4056	HealthPlus Partners	HPP	6,863	50.2%	8,946	31.3%
4243	M-CAID	MCD	1,344	73.2%	1,524	64.5%
4312	McLaren Health Plan	MCL	1,664	53.5%	2,338	40.6%
4131	Midwest Health Plan	MID	3,995	65.3%	6,067	39.8%
4151	Molina Healthcare of Michigan	MOL	2,215	36.2%	3,942	26.7%
4055	OmniCare Health Plan	OCH	7,094	44.0%	11,185	29.2%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	2,685	53.3%	3,655	39.2%
4283	Physician's Health Plan of Southwest Michigan	PSW	2,959	53.0%	3,791	29.4%
4054	Priority Health Government Programs	PRI	3,106	61.5%	3,045	38.4%
4268	Total Health Care	THC	4,641	43.5%	7,675	27.8%
4348	Upper Peninsula Health Plan	UPP	2,158	56.7%	3,317	31.1%
4218	The Wellness Plan	TWP	12,526	47.2%	20,555	25.8%

2003 Michigan Medicaid Weighted Average	52.0%	32.1%
2002 Michigan Medicaid Weighted Average	52.6%	29.0%
2001 Michigan Medicaid Weighted Average	44.9%	24.3%
National HEDIS 2002 Medicaid 50th Percentile	57.1%	30.8%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

R denotes a *Report* audit designation.
NR denotes a *Not Report* audit designation.
NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-4—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Cancer Screening in Women

			Breast Cancer Screening		Cervical Cancer Screening	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	85	61.9%	898	54.0%
4333	Cape Health Plan	CAP	1,002	49.7%	6,228	53.3%
4139	Community Care Plan	CCP	492	63.8%	3,939	68.1%
4265	Community Choice Michigan	CCM	958	54.3%	9,174	69.8%
4133	Great Lakes Health Plan	GLH	1,925	52.7%	11,400	52.5%
4291	Health Plan of Michigan	HPM	576	61.3%	4,433	58.6%
4056	HealthPlus Partners	HPP	1,097	67.0%	8,328	72.1%
4243	M-CAID	MCD	172	49.4%	1,377	74.8%
4312	McLaren Health Plan	MCL	274	69.0%	2,089	58.4%
4131	Midwest Health Plan	MID	792	50.1%	5,005	50.2%
4151	Molina Healthcare of Michigan	MOL	473	49.3%	3,282	51.3%
4055	OmniCare Health Plan	OCH	1,489	50.9%	9,545	50.4%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	409	64.5%	3,251	58.6%
4283	Physician's Health Plan of Southwest Michigan	PSW	392	69.4%	2,895	66.1%
4054	Priority Health Government Programs	PRI	351	62.0%	2,967	78.2%
4268	Total Health Care	THC	978	44.4%	6,288	52.3%
4348	Upper Peninsula Health Plan	UPP	369	72.6%	2,339	66.6%
4218	The Wellness Plan	TWP	1,929	58.6%	15,855	63.3%

2003 Michigan Medicaid Weighted Average	56.2%	60.2%
2002 Michigan Medicaid Weighted Average	55.5%	59.4%
2001 Michigan Medicaid Weighted Average	53.8%	53.2%
National HEDIS 2002 Medicaid 50th Percentile	56.3%	60.2%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

R denotes a *Report* audit designation.
NR denotes a *Not Report* audit designation.
NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-5—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Chlamydia Screening in Women

			Ages 16 to 20 Years		Ages 21 to 26 Years		Combined Rate	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	106	58.4%	122	61.9%	228	60.3%
4333	Cape Health Plan	CAP	558	40.3%	706	43.6%	1,264	42.2%
4139	Community Care Plan	CCP	616	40.2%	734	42.3%	1,350	41.3%
4265	Community Choice Michigan	CCM	1,215	42.1%	1,624	49.1%	2,839	46.1%
4133	Great Lakes Health Plan	GLH	1,278	28.1%	1,251	31.7%	2,529	29.9%
4291	Health Plan of Michigan	HPM	710	43.8%	631	47.6%	1,341	45.6%
4056	HealthPlus Partners	HPP	1,044	30.1%	1,585	31.1%	2,629	30.7%
4243	M-CAID	MCD	168	34.5%	245	47.8%	413	42.4%
4312	McLaren Health Plan	MCL	234	38.0%	309	48.2%	543	43.8%
4131	Midwest Health Plan	MID	441	39.7%	545	46.4%	986	43.4%
4151	Molina Healthcare of Michigan	MOL	406	36.2%	430	35.1%	836	35.7%
4055	OmniCare Health Plan	OCH	960	43.6%	1,256	44.7%	2,216	44.2%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	374	45.6%	530	54.6%	904	50.9%
4283	Physician's Health Plan of Southwest Michigan	PSW	434	38.6%	575	46.7%	1,009	43.2%
4054	Priority Health Government Programs	PRI	383	42.8%	686	50.8%	1,069	48.0%
4268	Total Health Care	THC	750	42.6%	856	48.3%	1,606	45.7%
4348	Upper Peninsula Health Plan	UPP	362	47.0%	369	40.7%	731	43.8%
4218	The Wellness Plan	TWP	2,076	57.3%	2,229	61.0%	4,305	59.2%
	2003 Michigan Medicaid Weighted Average			42.1%		45.9%		44.2%
	2002 Michigan Medicaid Weighted Average			33.0%		37.9%		35.8%
	2001 Michigan Medicaid Weighted Average			31.4%		33.8%		33.1%
	National HEDIS 2002 Medicaid 50th Percentile			37.1%		39.5%		38.5%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

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NR denotes a *Not Report* audit designation.
NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-6—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Prenatal and Postpartum Care

DST	Plan Name	Code	Eligible Population	Timeliness of Prenatal Care Rate	Postpartum Care Rate
4136	Botsford Health Plan	BOT	83	51.2%	24.4%
4333	Cape Health Plan	CAP	681	65.2%	34.3%
4139	Community Care Plan	CCP	557	76.7%	50.1%
4265	Community Choice Michigan	CCM	1,316	72.5%	45.1%
4133	Great Lakes Health Plan	GLH	1,095	67.2%	52.3%
4291	Health Plan of Michigan	HPM	661	66.0%	50.2%
4056	HealthPlus Partners	HPP	1,064	80.9%	53.7%
4243	M-CAID	MCD	167	80.0%	52.7%
4312	McLaren Health Plan	MCL	295	73.5%	52.6%
4131	Midwest Health Plan	MID	546	53.1%	34.8%
4151	Molina Healthcare of Michigan	MOL	253	61.4%	41.8%
4055	OmniCare Health Plan	OCH	1,114	31.9%	29.0%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	440	70.5%	53.2%
4283	Physician's Health Plan of Southwest Michigan	PSW	455	82.2%	63.0%
4054	Priority Health Government Programs	PRI	428	87.4%	60.1%
4268	Total Health Care	THC	723	65.5%	35.2%
4348	Upper Peninsula Health Plan	UPP	244	86.5%	60.2%
4218	The Wellness Plan	TWP	1,916	65.9%	39.6%
	2003 Michigan Medicaid Weighted Average			66.9%	44.9%
	2002 Michigan Medicaid Weighted Average			72.7%	51.2%
	2001 Michigan Medicaid Weighted Average			70.5%	50.5%
	National HEDIS 2002 Medicaid 50th Percentile			74.9%	54.5%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

R denotes a *Report* audit designation.
NR denotes a *Not Report* audit designation.
NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-7—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Comprehensive Diabetes Care (Part 1)

DST	Plan Name	Code	Eligible Population	HbA1c Testing Rate	Poor HbA1c Control Rate	Eye Exam Rate
4136	Botsford Health Plan	BOT	138	79.9%	47.0%	49.3%
4333	Cape Health Plan	CAP	1,119	67.2%	52.6%	42.1%
4139	Community Care Plan	CCP	674	87.5%	42.4%	50.6%
4265	Community Choice Michigan	CCM	1,477	74.4%	44.6%	34.0%
4133	Great Lakes Health Plan	GLH	2,098	68.9%	47.7%	47.7%
4291	Health Plan of Michigan	HPM	739	77.3%	47.0%	41.7%
4056	HealthPlus Partners	HPP	1,263	80.7%	59.1%	48.7%
4243	M-CAID	MCD	205	87.5%	31.8%	59.4%
4312	McLaren Health Plan	MCL	338	79.0%	47.9%	49.2%
4131	Midwest Health Plan	MID	986	64.5%	60.7%	28.1%
4151	Molina Healthcare of Michigan	MOL	552	77.4%	55.8%	39.3%
4055	OmniCare Health Plan	OCH	1,563	59.1%	41.1%	41.1%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	487	83.7%	34.8%	62.0%
4283	Physician's Health Plan of Southwest Michigan	PSW	502	82.5%	35.3%	40.1%
4054	Priority Health Government Programs	PRI	444	85.4%	26.7%	58.7%
4268	Total Health Care	THC	1,101	60.8%	66.0%	30.3%
4348	Upper Peninsula Health Plan	UPP	363	91.1%	28.4%	63.3%
4218	The Wellness Plan	TWP	2,391	75.8%	40.8%	51.0%

2003 Michigan Medicaid Weighted Average	73.2%	47.1%	44.3%
2002 Michigan Medicaid Weighted Average	68.4%	47.5%	40.6%
2001 Michigan Medicaid Weighted Average	59.5%	58.5%	38.0%
National HEDIS 2002 Medicaid 50th Percentile	73.2%	47.4%	46.4%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

R denotes a *Report* audit designation.
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NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-8—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Comprehensive Diabetes Care (Part 2)

DST	Plan Name	Code	Eligible Population	LDL-C Screening Rate	LDL-C Level Rate	Monitoring Nephropathy Rate
4136	Botsford Health Plan	BOT	138	66.4%	38.1%	38.8%
4333	Cape Health Plan	CAP	1,119	65.7%	42.6%	26.8%
4139	Community Care Plan	CCP	674	77.9%	54.0%	51.3%
4265	Community Choice Michigan	CCM	1,477	69.8%	44.6%	47.2%
4133	Great Lakes Health Plan	GLH	2,098	70.7%	45.5%	36.2%
4291	Health Plan of Michigan	HPM	739	69.0%	38.9%	47.7%
4056	HealthPlus Partners	HPP	1,263	74.6%	39.6%	53.3%
4243	M-CAID	MCD	205	88.5%	56.8%	68.8%
4312	McLaren Health Plan	MCL	338	68.9%	47.3%	51.1%
4131	Midwest Health Plan	MID	986	67.2%	40.0%	52.6%
4151	Molina Healthcare of Michigan	MOL	552	63.2%	36.6%	42.7%
4055	OmniCare Health Plan	OCH	1,563	56.0%	38.0%	36.3%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	487	84.2%	55.7%	55.2%
4283	Physician's Health Plan of Southwest Michigan	PSW	502	76.6%	44.8%	40.6%
4054	Priority Health Government Programs	PRI	444	84.9%	62.9%	55.2%
4268	Total Health Care	THC	1,101	61.5%	37.8%	39.0%
4348	Upper Peninsula Health Plan	UPP	363	84.6%	55.0%	62.7%
4218	The Wellness Plan	TWP	2,391	67.3%	44.3%	68.3%
	2003 Michigan Medicaid Weighted Average			69.2%	43.8%	47.6%
	2002 Michigan Medicaid Weighted Average			62.1%	36.3%	41.0%
	2001 Michigan Medicaid Weighted Average			50.1%	24.5%	32.8%
	National HEDIS 2002 Medicaid 50th Percentile			68.5%	38.0%	41.6%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

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Table B-9—Michigan Medicaid HEDIS 2003 Tabular Results for Key Measures: Use of Appropriate Medications for People with Asthma

			Ages 5 to 9 Years		Ages 10 to 17 Years		Ages 18 to 56 Years		Combined Rate	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	10	NA	27	NA	45	68.9%	82	64.6%
4333	Cape Health Plan	CAP	139	51.1%	187	51.9%	478	65.3%	804	59.7%
4139	Community Care Plan	CCP	94	66.0%	143	74.8%	303	70.0%	540	70.6%
4265	Community Choice Michigan	CCM	201	62.7%	318	63.8%	667	65.5%	1,186	64.6%
4133	Great Lakes Health Plan	GLH	276	44.2%	392	57.4%	836	66.5%	1,504	60.0%
4291	Health Plan of Michigan	HPM	145	63.4%	186	55.9%	414	69.6%	745	65.0%
4056	HealthPlus Partners	HPP	294	72.1%	381	72.7%	719	70.2%	1,394	71.3%
4243	M-CAID	MCD	81	69.1%	97	76.3%	122	80.3%	300	76.0%
4312	McLaren Health Plan	MCL	63	63.5%	77	67.5%	159	64.8%	299	65.2%
4131	Midwest Health Plan	MID	144	41.0%	159	48.4%	410	64.6%	713	56.2%
4151	Molina Healthcare of Michigan	MOL	39	56.4%	65	55.4%	253	64.4%	357	61.9%
4055	OmniCare Health Plan	OCH	497	46.3%	654	54.7%	983	66.5%	2,134	58.2%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	164	72.6%	174	66.7%	303	67.0%	641	68.3%
4283	Physician's Health Plan of Southwest Michigan	PSW	83	63.9%	153	62.7%	238	69.7%	474	66.5%
4054	Priority Health Government Programs	PRI	110	75.5%	149	75.8%	241	66.4%	500	71.2%
4268	Total Health Care	THC	205	60.0%	372	55.4%	503	66.4%	1,080	61.4%
4348	Upper Peninsula Health Plan	UPP	58	74.1%	117	65.8%	263	71.1%	438	70.1%
4218	The Wellness Plan	TWP	725	61.2%	905	63.6%	1,350	64.4%	2,980	63.4%

2003 Michigan Medicaid Weighted Average	59.0%	61.7%	66.9%	63.8%
2002 Michigan Medicaid Weighted Average	59.4%	62.7%	68.2%	64.9%
2001 Michigan Medicaid Weighted Average	51.8%	57.7%	60.8%	58.1%
National HEDIS 2002 Medicaid 50th Percentile	55.4%	58.8%	64.1%	60.8%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

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Table B-10—Michigan Medicaid HEDIS 2003 Tabular Results, Key Measures Controlling High Blood Pressure

DST	Plan Name	Code	Eligible Population	Rate
4136	Botsford Health Plan	BOT	124	54.2%
4333	Cape Health Plan	CAP	473	50.4%
4139	Community Care Plan	CCP	251	52.2%
4265	Community Choice Michigan	CCM	968	59.3%
4133	Great Lakes Health Plan	GLH	1,555	52.1%
4291	Health Plan of Michigan	HPM	460	59.1%
4056	HealthPlus Partners	HPP	1,007	61.0%
4243	M-CAID	MCD	148	71.1%
4312	McLaren Health Plan	MCL	234	60.9%
4131	Midwest Health Plan	MID	627	54.8%
4151	Molina Healthcare of Michigan	MOL	203	43.8%
4055	OmniCare Health Plan	OCH	1,312	24.3%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	323	56.1%
4283	Physician's Health Plan of Southwest Michigan	PSW	343	59.4%
4054	Priority Health Government Programs	PRI	366	67.8%
4268	Total Health Care	THC	840	43.8%
4348	Upper Peninsula Health Plan	UPP	301	65.1%
4218	The Wellness Plan	TWP	1,805	56.9%

2003 Michigan Medicaid Weighted Average	52.3%
2002 Michigan Medicaid Weighted Average	52.7%
2001 Michigan Medicaid Weighted Average*	___
National HEDIS 2002 Medicaid 50th Percentile	54.6%

Note: *The 2002 Michigan Medicaid Weighted Average includes 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

**Controlling High Blood Pressure was not a Key Measure in 2001; therefore, no weighted average was calculated.*

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NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a *Not Applicable* (NA) audit designation.

Table B-11—Michigan Medicaid HEDIS 2003 Tabular Results, Key Measures
Medical Assistance with Smoking Cessation – Advising Smokers to Quit

DST	Plan Name	Code	Rate
4136	Botsford Health Plan	BOT	67.7%
4333	Cape Health Plan	CAP	66.5%
4139	Community Care Plan	CCP	65.2%
4265	Community Choice Michigan	CCM	66.0%
4133	Great Lakes Health Plan	GLH	61.0%
4291	Health Plan of Michigan	HPM	63.5%
4056	HealthPlus Partners	HPP	69.0%
4243	M-CAID	MCD	71.6%
4312	McLaren Health Plan	MCL	65.1%
4131	Midwest Health Plan	MID	61.0%
4151	Molina Healthcare of Michigan	MOL	71.1%
4055	OmniCare Health Plan	OCH	64.9%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	69.6%
4283	Physician's Health Plan of Southwest Michigan	PSW	64.1%
4054	Priority Health Government Programs	PRI	71.4%
4268	Total Health Care	THC	66.7%
4348	Upper Peninsula Health Plan	UPP	65.8%
4218	The Wellness Plan	TWP	62.0%

2003 Michigan Medicaid Average (not weighted)	66.2%

Notes: *Medical Assistance with Smoking Cessation—Advising Smokers to Quit is now calculated using a two-year rolling average. Rates are reported using data from the most recent two reporting years, with the rolling average of 2002 and 2003 shown above. Since this is the first time the two-year rolling average is reported, comparison to 2002 data alone is not valid.*

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Table B-12—Michigan Medicaid HEDIS 2003 Tabular Results, Key Measures
Children's Access to Primary Care Practitioners

			Ages 12 to 24 Months		Ages 25 Months to 6 Years		Ages 7 to 11 Years	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	136	80.1%	738	71.4%	426	66.2%
4333	Cape Health Plan	CAP	1,610	90.8%	6,129	76.9%	3,877	76.7%
4139	Community Care Plan	CCP	1,138	95.0%	4,804	81.3%	2,548	82.6%
4265	Community Choice Michigan	CCM	1,902	91.1%	9,045	76.2%	5,982	76.4%
4133	Great Lakes Health Plan	GLH	2,420	89.5%	10,716	76.6%	7,122	76.9%
4291	Health Plan of Michigan	HPM	1,119	95.5%	4,850	82.8%	4,378	75.9%
4056	HealthPlus Partners	HPP	1,912	97.4%	8,538	84.8%	6,092	83.6%
4243	M-CAID	MCD	488	96.1%	1,823	86.7%	1,078	91.7%
4312	McLaren Health Plan	MCL	516	93.4%	2,081	78.7%	1,130	81.3%
4131	Midwest Health Plan	MID	1,128	88.9%	5,018	80.3%	3,537	82.0%
4151	Molina Healthcare of Michigan	MOL	493	82.2%	2,727	69.0%	1,478	77.7%
4055	OmniCare Health Plan	OCH	1,463	76.8%	8,678	60.2%	8,090	59.9%
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	764	92.9%	3,402	78.9%	2,217	79.6%
4283	Physician's Health Plan of Southwest Michigan	PSW	931	96.0%	3,707	81.5%	2,174	83.5%
4054	Priority Health Government Programs	PRI	896	95.9%	3,942	81.6%	2,256	80.1%
4268	Total Health Care	THC	1,107	80.8%	5,695	63.9%	5,049	67.1%
4348	Upper Peninsula Health Plan	UPP	602	96.3%	2,713	86.5%	1,886	83.7%
4218	The Wellness Plan	TWP	2,791	92.6%	15,257	72.4%	14,837	70.4%
	2003 Michigan Medicaid Weighted Average			91.0%		75.9%		74.7%
	2002 Michigan Medicaid Weighted Average			85.9%		70.9%		71.6%
	2001 Michigan Medicaid Weighted Average			91.2%		74.9%		74.0%
	National HEDIS 2002 Medicaid 50th Percentile			92.1%		80.7%		80.9%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

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Table B-13—Michigan Medicaid HEDIS 2003 Tabular Results, Key Measures
Adults' Access to Preventive/Ambulatory Health Services

			Ages 20 to 44 Years		Ages 45 to 64 Years		Ages 65+	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	903	64.5%	414	73.2%	0	NA
4333	Cape Health Plan	CAP	5,730	66.2%	3,797	73.1%	9	NA
4139	Community Care Plan	CCP	4,015	82.4%	1,672	89.7%	6	NA
4265	Community Choice Michigan	CCM	9,769	74.8%	3,691	83.5%	5	NA
4133	Great Lakes Health Plan	GLH	10,494	75.0%	6,661	83.9%	42	81.0%
4291	Health Plan of Michigan	HPM	4,419	77.8%	1,922	85.8%	25	NA
4056	HealthPlus Partners	HPP	8,446	82.6%	3,437	91.4%	11	NA
4243	M-CAID	MCD	1,580	86.1%	678	92.0%	13	NA
4312	McLaren Health Plan	MCL	2,111	77.6%	911	88.6%	2	NA
4131	Midwest Health Plan	MID	4,908	74.6%	2,974	81.8%	9	NA
4151	Molina Healthcare of Michigan	MOL	3,421	71.2%	1,741	78.9%	2	NA
4055	OmniCare Health Plan	OCH	8,819	63.7%	4,764	75.2%	4	NA
4282	Physician's Health Plan of Mid Michigan Family Care	PMD	3,299	77.4%	1,382	85.7%	6	NA
4283	Physician's Health Plan of Southwest Michigan	PSW	2,907	81.6%	1,248	91.7%	3	NA
4054	Priority Health Government Programs	PRI	2,811	83.7%	1,012	92.2%	5	NA
4268	Total Health Care	THC	6,066	62.7%	3,428	71.1%	10	NA
4348	Upper Peninsula Health Plan	UPP	2,380	86.8%	1,198	91.5%	0	NA
4218	The Wellness Plan	TWP	15,357	71.7%	6,996	76.9%	25	NA
	2003 Michigan Medicaid Weighted Average			74.1%		81.4%		76.8%
	2002 Michigan Medicaid Weighted Average			74.4%		82.5%		82.5%
	2001 Michigan Medicaid Weighted Average*			—		—		—
	National HEDIS 2002 Medicaid 50th Percentile			75.1%		82.9%		79.5%

Note: *The 2001 and 2002 Michigan Medicaid Weighted Averages include 19 health plans; however, the 2003 Michigan Medicaid Weighted Average includes 18 health plans. Care Choices HMO is no longer a contracted Medicaid health plan.*

**Adults' Access to Preventive/Ambulatory Health Services was not a Key Measure in 2001; therefore, no weighted average was calculated.*

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NR denotes a *Not Report* audit designation.

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APPENDIX C. National HEDIS 2002 Medicaid Percentiles

Table C-1—National HEDIS 2002 Medicaid Percentiles – Pediatric Care

Measure	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
Childhood Immunization Status—Combination #1	40.0%	51.3%	60.7%	66.7%	74.3%
Childhood Immunization Status—Combination #2	33.8%	42.8%	53.8%	62.3%	68.1%
Adolescent Immunization Status—Combination #1	16.6%	23.8%	33.6%	46.6%	59.6%
Adolescent Immunization Status—Combination #2	4.1%	8.0%	13.0%	22.6%	38.7%
Well-Child Visits in the First 15 Months—Zero Visits*	1.0%	2.2%	4.5%	8.4%	16.0%
Well-Child Visits in the First 15 Months—Six or More Visits	14.4%	26.7%	35.7%	46.7%	58.9%
Well-Child in the Third, Fourth, Fifth and Sixth Years of Life	37.9%	46.9%	57.1%	65.1%	68.1%
Adolescent Well-Care Visits	19.9%	25.2%	30.8%	39.4%	46.6%

* Note that, for this Key Measure, a lower rate indicates better performance.

Table C-2—National HEDIS 2002 Medicaid Percentiles – Women's Care

Measure	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
Cervical Cancer Screening	42.6%	50.6%	60.2%	70.5%	76.0%
Breast Cancer Screening	42.6%	49.4%	56.3%	62.0%	67.3%
Chlamydia Screening in Women—Ages 16 to 20 Years	18.8%	28.6%	37.1%	48.5%	57.4%
Chlamydia Screening in Women—Ages 21 to 26 years	17.0%	26.5%	39.5%	50.0%	58.0%
Chlamydia Screening in Women—Combined Rate	18.0%	28.4%	38.5%	48.0%	57.0%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	50.1%	63.9%	74.9%	83.7%	88.7%
Prenatal and Postpartum Care—Postpartum Care	34.4%	44.0%	54.5%	59.3%	65.6%

Table C-3—National HEDIS 2002 Medicaid Percentiles – Living with Illness

Measure	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
Comprehensive Diabetes Care—Eye Exam	18.1%	31.9%	46.4%	55.2%	64.3%
Comprehensive Diabetes Care—HbA1c Testing	47.9%	65.5%	73.2%	80.5%	84.8%
Comprehensive Diabetes Care—Poor HbA1c Control*	32.8%	40.1%	47.4%	60.3%	70.6%
Comprehensive Diabetes Care—LDL-C Screening	47.9%	58.5%	68.5%	73.3%	81.0%
Comprehensive Diabetes Care—LDL-C Level	20.2%	29.6%	38.0%	46.7%	51.2%
Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy	24.3%	34.9%	41.6%	49.3%	54.5%
Use of Appropriate Medications for People with Asthma—Ages 5 to 9 Years	37.0%	47.4%	55.4%	62.0%	70.0%
Use of Appropriate Medications for People with Asthma—Ages10 to 17 Years	41.1%	49.8%	58.8%	65.6%	69.0%
Use of Appropriate Medications for People with Asthma—Ages 18 to 56 Years	49.6%	55.3%	64.1%	68.1%	74.0%
Use of Appropriate Medications for People with Asthma—Combined Rate	43.8%	54.3%	60.8%	64.8%	69.5%
Controlling High Blood Pressure	36.6%	46.1%	54.6%	58.7%	63.7%

* Note that, for this Key Measure, a lower rate indicates better performance.

Table C-4—National HEDIS 2002 Medicaid Percentiles – Access to Care

Measure	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
Children's Access to Primary Care Practitioners— Ages 12 to 24 Months	83.2%	89.0%	92.1%	96.0%	97.3%
Children's Access Primary Care Practitioners— Ages 25 Months to 6 Years	69.1%	74.9%	80.7%	85.7%	88.2%
Children's Access Primary Care Practitioners— Ages 7 to 11 Years	67.3%	74.4%	80.9%	85.7%	89.6%
Adults' Access to Preventive/Ambulatory Services - Ages 20 to 44 Years	59.2%	67.3%	75.1%	81.8%	86.0%
Adults' Access to Preventive/Ambulatory Services - Ages 45 to 64 Years	67.4%	77.1%	82.9%	86.2%	88.9%
Adults' Access to Preventive/Ambulatory Services - Ages 65 +	64.7%	68.1%	79.5%	86.6%	87.8%

Terms, Acronyms, and Abbreviations

Administrative Data

Any automated data within a health plan (e.g., claims/encounter data, member data, provider data, hospital billing data, pharmacy data, and laboratory data).

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data. In addition, the numerator(s), or services provided to the members who are in the eligible population, are solely derived from administrative data. Medical records cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

The administrative method is cost efficient, but can produce lower rates due to incomplete data submission by capitated providers. For example, a health plan has 10,000 members who qualify for the Prenatal and Postpartum Care measure. The health plan chooses to perform the administrative method and finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using administrative data. The final rate for this measure, using the administrative method, would therefore be 4,000/10,000, or 40 percent.

Audit Designation

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates. Each measure included in the HEDIS audit receives either a "Report designation" or a "Not Report" designation, along with the rationale for why the measure received that particular designation.

Baseline Assessment Tool (BAT) Review

The BAT, completed by each health plan undergoing the HEDIS audit process, provides information to auditors regarding the health plan's systems for collecting and processing data for HEDIS reporting. Auditors review the BAT prior to the scheduled on-site health plan visit to gather preliminary information for: planning/targeting on-site visit assessment activities; determining the core set of measures to be reviewed; determining which hybrid measures will be included in medical record validation; requesting core measures source code, as needed; identifying areas that require additional clarification during the on-site visit; and determining whether the core set of measures needs to be expanded.

BRFSS

Behavioral Risk Factor Surveillance System

CAHPS® 2.0H

Consumer Assessment of Health Plans Survey is a set of standardized surveys that assess patient satisfaction with experience of care.

Capitation

A method of payment for providers. Under a capitated payment arrangement, providers are reimbursed on a per member/per month basis. The provider receives payment each month, regardless of whether the member needed services or not. Therefore, there is little incentive for providers to submit individual encounters, knowing that payment is not dependent on such submission.

Certified HEDIS Software Vendor

A third party, whose source code has been certified by NCQA, that contracts with a health plan to write source code for HEDIS measures. For a vendor's software to be certified by NCQA, all of the vendor's programmed HEDIS measures must be submitted to NCQA for automated testing of program logic, and a minimum of 70 percent of the measures must receive a "Pass" or "Pass with Qualifications" designation.

Claims Based Denominator

When the eligible population for a measure is obtained from claims data. For claims-based denominator hybrid measures, health plans must identify their eligible population and draw their sample no earlier than January of the year following the measurement year to ensure all claims incurred through December 31 of the measurement year are captured in their systems.

CMS (formerly known as HCFA)

The Centers for Medicare & Medicaid Services (CMS) provides health insurance to individuals through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). In addition, CMS also regulates laboratory testing through Clinical Laboratory Improvement Amendments (CLIA), develops coverage policies, and initiates quality of care improvement activities. CMS also maintains oversight of nursing homes and continuing care providers. This includes home health agencies, intermediate care facilities for the mentally retarded, and hospitals.

Cohorts

Population components of a measure based on the age of the member at a particular point in time. A separate HEDIS rate is calculated for each cohort in a measure. For example, the Children's Access to Primary Care Practitioners measure has three cohorts: Cohort 1, 12–24 months old as of December 31 of the measurement year; Cohort 2, 25 months–6 years old as of December 31 of the measurement year; and Cohort 3, 7–11 years old as of December 31 of the measurement year.

Computer Logic

Programmed, step-by-step sequence of instructions to perform a given task.

Continuous Enrollment Requirement

The minimum amount of time that a member must be enrolled in a health plan to be eligible for inclusion in a measure to ensure that the health plan has a sufficient amount of time to be held accountable for providing services to that member.

For a full HEDIS audit, the process auditors follow to select the core set of measures to be reviewed in detail during the audit process. The core set of measures must include 13 measures across all domains of care, and represent all data sources, all product lines/products, and all intricacies of health plan data collection and reporting. In addition, the core set must focus on any health plan weaknesses identified during the BAT review. The core set can be expanded to more than 13 measures, but cannot be less than 13 measures. Rotated measures are not included in the core set.

CPT™

Current Procedural Terminology (CPT) is a listing of billing codes used to document the provision of medical services and procedures.

CVO

Credentials Verification Organization

Data Completeness

The degree to which actually occurring services/diagnoses appear in the health plan's administrative data systems.

Data Completeness Study

An internal assessment developed and performed by a health plan, using a statistically sound methodology, to quantify the degree to which actually occurring services/diagnoses appear or do not appear in the health plan's administrative data systems.

Denominator

The number of members who meet all criteria specified in the measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.

DRG Coding

Diagnostic-Related Group (DRG) coding sorts diagnoses and procedures by groups under major diagnostic categories with defined reimbursement limits.

DST

Data Submission Tool: The tool used to report HEDIS data to NCQA.

DtaP

Diphtheria, tetanus, and acellular pertussis vaccine

DT

Diphtheria and tetanus vaccine

EDI

Electronic Data Interchange (EDI) is the direct computer-to-computer transfer of data.

Electronic Data

Data that are maintained in a computer environment versus a paper environment.

Encounter Data

Billing data received from a capitated provider. Although the health plan does not reimburse the provider for each individual encounter, submission of the encounter data to the health plan allows the health plan to collect the data for future HEDIS reporting.

Exclusions

Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.

FACCT

Foundation for Accountability

FFS

Fee-for-service: A reimbursement mechanism where the provider is paid for services billed.

Final Report

Following the health plan's completion of any corrective actions, the written report that is completed by the auditor documenting all final findings and results of the HEDIS audit. The final report includes the Summary Report, IS Capabilities Assessment, Medical Record Review Validation Findings, Measure Designations, and Audit Opinion (Final Audit Statement).

Full HEDIS Audit

A full audit occurs when the HEDIS auditor selects a sample of measures (core set) that represent all HEDIS domains of care and extrapolates the findings on that sample to the entire set of HEDIS measures. Health plans that undergo a full audit can use the NCQA seal in marketing materials.

Global Billing

The practice of billing multiple services provided over a period of time in one inclusive bill, commonly used by OB providers to bill prenatal and postpartum care.

HbA1c

The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) is a lab test which reveals average blood glucose over a period of two to three months.

HCFA 1500

A type of claim form used to bill professional services.

HCPC

Healthcare Common Procedure Coding system. A standardized claims payment and coding system that maps directly to CPT codes. (See also *CPT*.)

HEDIS

The Health Plan Employer Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

HEDIS Measure Determination Standards (HD)

The standards that auditors use during the audit process to assess a health plan's adherence to HEDIS measure specifications.

HEDIS Repository

The data warehouse where all data used for HEDIS reporting are stored.

HEDIS Warehouse

See HEDIS repository.

HiB

H influenza type b vaccine

HPL

High performance level. MDCH has defined the HPL as the most recent national HEDIS Medicaid 90th percentile, except for two Key Measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care – Poor HbA1c Control*) for which lower rates indicate better performance. For these two measures, the 10th percentile (rather than the 90th) shows excellent performance.

Hybrid Measures

Measures that can be reported using the hybrid method.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data, and then extract a systematic sample of 411 members from the eligible population, which becomes the denominator. Administrative data are then used to identify services provided to those 411 members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher results, but is considerably more labor intensive. For example, a health plan has 10,000 members who qualify for the Prenatal and Postpartum Care measure. The health plan chooses to perform the hybrid method. After randomly selecting 411 eligible members, the health plan finds that 161 members had evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would therefore be (161 + 54) /411, or 52 percent.

ICD-9-CM

ICD-9-CM, the acronym for the International Classification of Diseases, 9th Revision, Clinical Modification, is the statistical classification of diseases and injuries into groups according to established criteria that is used for billing purposes.

IHCS

Institute for Health Care Studies at Michigan State University

Inpatient Data

Data derived from an inpatient hospital stay.

IPV

Inactivated Polio Vaccine

IRR

Inter-rater reliability: The degree of agreement exhibited when a measurement is repeated under the same conditions by different raters.

IS

Information System: An automated system for collecting, processing, and transmitting data.

IT

Information Technology: The technology used to create, store, exchange, and use information in its various forms.

Key Data Elements

The data elements that must be captured to be able to report HEDIS measures.

Key Measures

The HEDIS measures selected by MDCH that health plans were required to report for HEDIS.

LDL-C

Low-Density Lipoprotein Cholesterol

Logic Checks

Evaluations of programming logic to determine its accuracy.

LPL

Low performance level. For most Key Measures, MDCH has defined the LPL as the most recent national HEDIS Medicaid 25th percentile. For two Key Measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care – Poor HbA1c Control*) lower rates indicate better performance, and the LPLs for these measures are the 75th percentile rather than the 25th.

Manual Data Collection

Collection of data through a paper versus an automated process.

Mapping Codes

The process of translating a health plan's propriety or nonstandard billing codes to industry standard codes specified in HEDIS measures. Mapping documentation should include a crosswalk of relevant codes, descriptions and clinical information, as well as the policies and procedures for implementing the codes.

Material Bias

For measures reported as a rate (which includes all of the Key Measures except *Advising Smokers to Quit*), any error that causes a ± 5 percent difference in the reported rate. For measures not reported as a rate (such as the key measure *Advising Smokers to Quit*), any error that causes a ± 10 percent difference in the reported rate.

MCIR

Michigan Childhood Immunization Registry

MCO

Managed Care Organization

MDCH

Michigan Department of Community Health

Medicaid Percentiles

The NCQA national average for each HEDIS measure for the Medicaid product line, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

Medical Record Validation

The process that auditors follow to verify that the health plan's medical record abstraction meets industry standards, and the abstracted data are accurate.

Membership Data

Electronic health plan files containing information about members, such as name, date of birth, gender, current address, and enrollment (i.e., when the member joined the health plan).

Mg/dL

Micrograms per deciliter

Modifier Codes

Two- or five-digit extensions added to CPT™ codes to provide additional information about services/procedures.

MMR

Measles, mumps, rubella vaccine

MUPC Codes

Michigan Uniform Procedure Codes: Procedures codes developed by the State of Michigan for billing services performed.

NA

Not applicable: The health plan did not offer the benefit or the denominator was too small (i.e., less than 30) to report a valid rate; the result/rate is NA.

NCQA

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.

NDC

National Drug Codes used for billing pharmacy services.

NR

Not Report HEDIS audit designation. There are three reasons a measure may be designated NR: (1) the health plan did not calculate the measure and a population existed for which the measure could have been calculated; (2) the health plan calculated the measure but chose not to report the result; or (3) the health plan calculated the measure but the result was materially biased.

Numerator

The number of members in the denominator who received all the services as specified in the measure.

OPV

Oral Polio Vaccine

Over-Read Process

The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data. The over-read process should be conducted by the health plan as part of their medical record review process, and auditors over-read a sample of the health plan's medical records as part of the audit process.

Partial HEDIS Audit

A partial audit occurs when the health plan, state regulator, or purchaser selects the HEDIS measures for audit. There may be any number of measures selected, but, unlike a full audit, findings are not extrapolated to the entire set of HEDIS measures. In addition, the health plan cannot use the NCQA seal in marketing materials.

Pharmacy Data

Data derived from the provision of pharmacy services.

Primary Source Verification

The practice of reviewing the processes and procedures to input, transmit, and track data from its originating source to the HEDIS repository to verify that the originating information matches the output information for HEDIS reporting.

Proprietary Codes

Unique billing codes developed by a health plan, which have to be mapped to industry standard codes for HEDIS reporting.

Provider Data

Electronic files containing information about physicians, such as type of physician, specialty, reimbursement arrangement, and office location.

Retroactive Enrollment

The effective date of a member's enrollment in a health plan occurs prior to the date that the health plan is notified of that member's enrollment. Medicaid members who are retroactively enrolled in a health plan must be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.

Revenue Codes

Billing codes used to identify services, procedures, supplies, or materials.

Sample Frame

In the hybrid method, the eligible population who meet all criteria specified in the measure from which the systematic sample is drawn.

Source Code

The written computer programming logic for determining the eligible population and denominators/numerators, and for calculating the rate for each measure.

Standard Codes

Industry standard billing codes such as ICD-9-CM, CPT™, DRG, Revenue, and UB-92 codes used for billing inpatient and outpatient health care services.

Studies on Data Completeness

Studies that health plans conduct to assess data completeness.

T-test Validation

A statistical validation of a health plan's positive medical record numerator events.

UB-92 Claims

A type of claim form used to bill hospital-based inpatient, outpatient, emergency room, and clinic drugs, supplies, and/or services. UB-92 codes are primarily Type of Bill and Revenue codes.

Vendor

Any third party that contracts with a health plan to perform services. The most common delegated services are: pharmacy vendors, vision care services, laboratory services, claims processing, HEDIS software vendors, and provider credentialing.

VZV

Varicella-Zoster Virus (chicken pox) vaccine